(1) (8) (8)

Nos. 93-1408, 93-1414, 93-1415

IN THE

Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

MARIO M. CUOMO, ET AL.,

Petitioners,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

(For Continuation of Caption See Reverse Side of Cover)

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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(For Further Appearances See Reverse Side of Cover)

PETITION FOR CERTIORARI FILED MARCH 9, 1994
CERTIORARI GRANTED OCTOBER 7, 1994

346pp

HOSPITAL ASSOCIATION OF NEW YORK STATE,

Petitioner,

vs.

THE TRAVELERS INSURANCE COMPANY, ET AL.,

Respondents.

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(6478—1994)

TABLE OF CONTENTS

The following opinions and orders have been omitted in printing this joint appendix because they appear on the following pages of the separately bound appendix to the printed petitions for a writ of certiorari.

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE TRAVELERS INSURANCE COMPANY,

Plaintiff,

-against-

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, LORNA MCBARNETTE, in her Official Capacity as Acting Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York,

Defendants.

Case No. 92 Civ. 3999 (LJF)

6/2/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120.00 RECEIPT # 170171 (jl) [Entry date 06/03/92]
6/26/92	5	ANSWER to Complaint by Mario M. Cuomo, Lorna McBarnette, Salvatore R. Curiale (Attorney M. Patricia Smith),; Firm of: Robert Abrams Attorney General State of New York by attorney M. Patricia Smith for defendant Mario M. Cuomo (jr)

8/3/92	14	STIPULATION and ORDER, New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield shall be permitted to intervene as parties deft in this action with full rights of parties, including to participate in oral argument (signed by Judge Louis J. Freeh). (emil)
8/5/92	15	ANSWER to Complaint by Empire Blue Cross, NY State Conference (Attorney Robert A. Bicks, Eileen M. Considine),; by attorney M. Patricia Smith for defendant Mario M. Cuomo (emil) [Entry date 08/07/92]
8/21/92	17	NOTICE OF MOTION by The Travelers Co. for summary judgment, Return date 8/21/92. Rule 3(g) Statement & Affidavits in support are attached (emil)
8/21/92	18	MEMORANDUM by The Travelers Co. in support of [17-1] motion for summary judgment (emil)
8/31/92	19	STIPULATION and ORDER, that the Hospital Association of New York State be permitted to intervene as a party deft in this action subject to the following limitation: Until pltff's motion for summary judgment is disposed of, Intervenor will not initiate discovery other than discovery directly related to discovery initiated by any other party. Intervenor agrees to comply with the schedule for motions and cross-motion for summary judgment which was agreed to by the parties on 7/14/92 (signed by Judge Louis J. Freeh). (emil) [Entry date 09/01/92]

9/28/92	21	ANSWER to Complaint by Hospital Association; Firm of: Sherrin & Glasel (emil)
10/2/92	23	NOTICE OF CROSS MOTION by Hospital Association for summary judgment, Return date 10/26/92. Rule 3(g) statement in support is attached (emil)
10/2/92	24	MEMORANDUM by Hospital Association in opposition to [17-1] motion for summary judgment and in support of cross-motion for summary judgment (emil)
10/2/92	25	AFFIDAVIT in support of Daniel Sisto Re: [23-1] cross motion for summary judgment (emil)
10/2/92	26	NOTICE OF CROSS MOTION by Empire Blue Cross, NY State Conference for summary judgment, Return date 10/26/92. Rule 3(g) Statement in support is attached (emil)
10/2/92	27	AFFIDAVIT in support of Arthur B. Klein Re: [26-1] cross motion for summary judgment (emil)
10/2/92	28	MEMORANDUM by New York State Conf, Empire Blue Cross in opposition to pltff's motion for a preliminary injunction (emil)
10/2/92	29	MEMORANDUM by Empire Blue Cross, NY State Conference in opposition to [17-1] motion for summary judgment (emil)
10/2/92	30	AFFIDAVIT in support of Jerry Weissman Re: [26-1] cross motion for summary judgment (emil)

10/2/92	31	AFFIDAVIT in support of Albert F. Antonini Re: [26-1] cross motion for summary judgment (emil)
10/5/92	32	NOTICE OF MOTION & CROSS MOTION by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin for summary judgment, Return date 10/26/92. Rule 3(g) Statement and Affidavits in support are attached (emil)
10/5/92	33	MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin in opposition to [17-1] motion for summary judgment and in support of defts' motion and cross-motions for summary judgment (emil)
10/5/92	34	RESPONSE by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin Re: pltffs' 3(g) Statement (emil)
10/5/92	35	RESPONSE by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin Re: pltff's 3(g) statement (emil)
10/19/92	37	STIPULATION and ORDER, that the NY State Health Maintenance Organization Conference, Health Services Medical Corporation, MVP Health Plan Wellcare, Mid-Hudson, Oxford Health Plan, Capital District Physicians Health Plan, ChoiceCare Long Island, Independent Health, Travelers of New York, Physicians Health Services, Preferred Care, and U.S. Healthcare (collectively referred to as "the HMO's") may intervene in said actions subject to the conditions listed in this Stip & Order (signed by Judge Louis J. Freeh). (emil) [Entry date 10/20/92]

10/21/92	38	REPLY MEMORANDUM by The Travelers Co. re: in support of [17-1] motion for summary judgment and in opposition to defendant's and intervenor's cross-motions for summary judgment. (emil) [Entry date 10/22/92]
10/21/92	39	RESPONSE by The Travelers Co. Re: Defendant's and Intervenor's statements pursuant to Rule 3(g) statement. (emil) [Entry date 10/22/92]
10/28/92	40	SUR-REPLY by Hospital Association Re: in opposition [17-1] motion for summary judgment and in support of its cross-motion for summary judgment (emil)
10/28/92	41	AFFIDAVIT in support of Darrell E. Jeffers Re: [23-1] cross motion for summary judgment (emil)
10/29/92	42	REPLY MEMORANDUM by Empire Blue Cross, NY State Conference re: [26-1] cross motion for summary judgment, [23-1] cross motion for summary judgment (emil)
10/29/92	44	RESPONSE by Empire Blue Cross, NY State Conference Re: pltffs' Health Ins. Association of America purs. to Southern Dist. Rule 3(g), dated October 21, 1992. (emil)
10/29/92	45	AFFIDAVIT of Jerry Weissman Re: in reply to the affidavits of Paul V. Bruno and Terence D. Tuohy (emil)

10/29/92	46	AFFIDAVIT of Alan Rachlin by Mario M. Cuomo, Salvatore R. Curiale (emil) [Entry date 10/30/92]
10/29/92	47	REPLY MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale re: motion & cross motions for summary judgment and in opposition to pltff's motions for summary judgment (emil) [Entry date 10/30/92]
11/6/92	52	AFFIDAVIT in support of Robert A. Sujecki Re: [17-1] motion for summary judgment (emil)
11/10/92	53	ORDER, consolidating this case with 92 cv 5419 for all pretrial and trial purposes (signed by Judge Louis J. Freeh); copies mailed (emil) [Entry date 11/12/92]
11/12/92	54	ORDER, Aetna Life Ins. Co. and Aetna Health Plans of NY, Inc.'s motion for a preliminary injunction is granted. Travelers and HIAA have also moved for summary judgment. All of these dispositive motions will be addressed in a separate opinion (signed by Judge Louis J. Freeh); Copies mailed (emil) [Entry date 11/13/92]
11/17/92	56	MEMORANDUM by New York State Conf, Empire Blue Cross re: [50-1] opposition memorandum (emil)
11/18/92	58	STIPULATION and ORDER, withdrawing Count II and III of the complaint (signed by Judge Louis J. Freeh). (emil) [Entry date 11/19/92]

12/2/92	62	Intervenor's COMPLAINT by NYSHMOC against Hospital Association, Empire Blue Cross, NY State Conference (emil) [Entry date 12/04/92]
12/21/92	66	ANSWER by Salvatore R. Curiale, Mark Chassin, Mary Jo Bane and Robert Abrams to [62-1] intervenor complaint by attorney (emil)
12/31/92	67	ANSWER by New York State Conf, Empire Blue Cross to [62-1] intervenor complaint Firm of: Hinman, Straub, Pigors etc. by attorney (emil)
1/11/93	68	MEMORANDUM by NYSHMOC in support of the motion for summary judgment of pltffs' Health Insurance Association of America, *et al* and in reply to deft's motion for summary judgment (emil)
2/3/93	69	MEMORANDUM OPINION #71013 granting in part, denying in part [17-1] motion for summary judgment, denying [26-1] cross motion for summary judgment, denying [23-1] cross motion for summary judgment, denying [32-1] motion for summary judgment. Because the Court finds that the three Surcharges are all preempted by ERISA, defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection with their coverage of any ERISA plans. Because the Court also finds that both the 11% and 13% Surcharges are preempted by FEHBA, defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program. Finally, because the

Court finds that Items 1,2,3 and 5 of the Actuarial Letter are also preempted under ERISA, defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans (signed by Judge Louis J. Freeh); Copies mailed. (emil) [Entry date 02/05/93]

2/8/93 70 NOTICE OF MOTION by New York State Conf, Empire Blue Cross to stay this Court's Opinion and Order dated 2/3/93 pending appeal, Return date 2/9/93 (emil)

2/8/93 71 MEMORANDUM by New York State Conf, Empire Blue Cross in support of [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/8/93 72 AFFIDAVIT in support of Bartley J. Costello by Empire Blue Cross Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/8/93 73 AFFIDAVIT in support of Jerry Weissman by Empire Blue Cross Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/9/93 74 MEMORANDUM by The Travelers Co. in opposition to [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/9/93 75 AFFIDAVIT in opposition of Timothy F. Lyons by The Travelers Co. Re: [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/9/93 76 MEMORANDUM OPINION #71044 granting in part, denying in part [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal. The Order will be stayed as to the 13% Surcharge, but not as to the 9% or 11% Surcharges. However, pltffs and any other parties subject to the 9% or 11% Surcharges shall pay those funds into an interest-bearing escrow account pending resolution of defts' appeal (Signed by Judge Louis J. Freeh); Copies mailed. (emil) [Entry date 02/10/93]

2/9/93 77 NOTICE OF APPEAL by Hospital Association; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Hinman, Straum, Pigors & Manning; Breed, Abbott & Morgan; Hogan & Hartson; Cough, White, Brenner, Howard & Feigenbaum; Office of the Attorney General; U.S. Atty's Office; Paul, Weiss, Rifkind, Wharton & Garrison; Windels, Marx, Davies & Ives. Appeal record due on 3/11/93 (emil) [Entry date 02/16/93]

2/16/93	78	NOTICE OF APPEAL by Mario M. Cuomo, Salvatore R. Curiale, Mark Chassin; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Craig P. Murphy; U.S. Atty, SDNY; Sherrin & Glasel; Hinman, Straub, Pigors & Manning; Breed, Abbott & Morgan. Appeal record due on 3/18/93 (emil) [Edit date 02/16/93]
2/19/93	79	NOTICE OF MOTION by Mario M. Cuomo, Salvatore R. Curiale to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, Return date 2/3/93. Affidavits in support attached. (emil)
2/19/93	80	MEMORANDUM by Mario M. Cuomo, Salvatore R. Curiale in support of [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit (emil)
2/22/93	81	AFFIDAVIT in opposition of Kathryn Allen by NYSHMOC Re: [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)
2/22/93	82	MEMORANDUM by NYSHMOC in opposition to [79-1] motion to stay the Order dated 2/3/93 pending appeal of that order to the USCA, 2nd Circuit, [70-1] motion to stay this Court's Opinion and Order dated 2/3/93 pending appeal (emil)

2/23/93	83	NOTICE OF APPEAL by New York State Conf, Empire Blue Cross; from [69-1] order. Copies of notice of appeal mailed to Attorney(s) of Record: Couch, White; Hogan & Hartson; Sherrin & Glasel; Carole Jeandheur; Windel, Marx; Robert Abrams; Lorraine Novinski; Paul, Weiss. (jf) [Entry date 02/24/93]
2/24/93	—	Notice of appeal and certified copy of docket to USCA: [83-1] appeal by Empire Blue Cross, New York State Conf; Copy of notice of appeal sent to District Judge. (jf)
3/5/93	84	NOTICE OF CROSS-APPEAL by The Travelers Co. from order dtd: 2/5/93. Copies sent to: Atty. Gen NYS; Robert Bicks; Philip Rosenberg; Bartley Costello; Harold Iselin; Clifford Stromberg. (jf) [Entry date 03/08/93]
3/10/93	85	Notice that the original record on appeal has been certified and transmitted to the U.S. Court of Appeals (emil) [Entry date 03/12/93]
4/28/93	86	ORDER, Pending a determination by the U.S.C.A., 2nd Circuit of the appeals from this Court's 2/3/93 order, the named parties to this action, including Travelers, in its capacity as claims fiduciary of the Railroad Plans, are directed to pay the 13% differential with respect to all hospital claims, where applicable

under Sec. 2807-c(1)(b) of the NY Public Health Law, whether incurred before or after the date hereof. This order applies to pltffs Health Ins. Association of America, American Council of Life Ins., and Life Ins. Council of NY, Inc. only to the extent they serve directly as fiduciaries of ERISA plans. This order does not impose on any person any obligation to pay the 13% differential except to the extent such obligation otherwise exists under the relevant contracts and/or NY law (signed by Judge Louis J. Freeh); Copies mailed (emil) [Entry date 05/06/93]

9/3/93 87 JUDGMENT that defts' cross-motions are denied. Pltffs' motions for summary judgment are granted in part and denied in part. Defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection w/their coverage of any ERISA plans because the Court finds that the three Surcharges are all preempted by ERISA. Defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program because the Court finds that both the 11% and 13% Surcharges are preempted by FEHBA. Defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans because the Court finds that Items 1, 2, 3 and 5 of the Actuarial Letter are also preempted under ERISA (signed by Judge Louis J. Freeh); Mailed copies and notice of right to appeal. (emil) [Entry date 09/09/93]

10/19/93 88 ORDER, to amend this Court's Opinion & Order of 2/9/93 to provide that: (1) pltffs may, at their option, pay some or all of the funds relating to the 11% supplementary payment rate conversion factor etc. instead of retaining them in an escrow account; and (2) pltff Aetna Health Plans of New York, Inc. and plaintiff-intervenor The Travelers Health Network, Inc. may pay, at their option, some or all of their funds relating to the 9% increase factor etc. instead of retaining them in an escrow account etc., that the judgment clerk amend the judgment entered on 9/9/93 in accordance with the foregoing (as indicated). (signed by Judge Morris E. Lasker); Copies mailed (sc) [Entry date 10/21/93]

11/3/93 89 JUDGMENT that defts' cross-motions are denied. Pltffs' motions for summary judgment are granted in part and denied in part. Defts are enjoined from enforcing those surcharges against any commercial insurers or HMOs in connection w/ their coverage of any ERISA plans because the Court finds that the three Surcharges are all preempted by ERISA. Defts are enjoined from enforcing those surcharges against any insurers participating in the FEHBA program because the Court finds that both the 11% and 13% Surcharges are preempted by FEHBA. Defts are enjoined from enforcing those provisions of the Letter against any commercial insurers providing stop-loss coverage to self-funded ERISA plans because the Court finds that Items 1, 2, 3 and 5 of the Actuarial Letter are also preempted under

ERISA. The Court's Opinion and Order of 2/9/93 is amended to provide that: 1) pltffs may, at their option, pay some or all of the funds relating to the 11% supplementary payment rate conversion factor purs. to the terms of NY's Omnibus Revenue Act of 1992, instead of retaining them in an escrow account and 2) pltff Aetna Health Plans of NY, Inc. and pltff-intervenor The Travelers Health Network, Inc. may pay, at their option, some or all of the funds relating to the 9% increase factor purs. to the terms of NY's Omnibus Revenue Act of 1992 instead of retaining them in an escrow account, and the Court's Order of 10/19/93 does not create an obligation on the part of self-insured plans to pay the 11% surcharge, and all payments made purs. to NY's Omnibus Revenue Act of 1992 may be under protest (Parkison, J., Clerk); Mailed copies and notice of right to appeal. (emil) [Entry date 11/04/93]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY AND PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs,

-against-

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, MARY JO BANE, in her Official Capacity as Commissioner of Social Services of the State of New York, SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York, and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Defendants.

Case No. 92 Civ. 5419 (LJF)

7/20/92	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $ 120.00 RECEIPT # 173340 (jl) [Entry date 07/22/92]
7/31/92	5	Notice of asgmnt to Judge Louis J. Freeh Copy of notice and judge's rules mailed to Attorney(s) of record: Sidney S. Rosdeitcher, Clifford D. Stromberg. (1a)
8/10/92	9	AMENDED COMPLAINT by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins., (Answer due 8/24/92 for Robert Abrams, for Salvatore R. Curiale, for Mary Jo Bane, for Mark Chassin) amending [1-1] complaint; Summons issued. (emil) [Entry date 08/18/92]
8/11/92	6	ANSWER to Complaint by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams (Attorney Jane Lauer Barker), (emil)
8/14/92	8	ANSWER by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams (Attorney) to amended complaint (emil) [Entry date 08/18/92]
8/19/92	12	STIPULATION and ORDER, New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield be permitted to intervene as parties deft in this action (signed by Judge Louis J. Freeh). (emil) [Entry date 08/20/92]

8/21/92	14	NOTICE OF MOTION by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins. for summary judgment, Return date 10/26/92. Rule 3(g) Statement and Affidavits in support are attached (emil) [Entry date 09/01/92]
8/21/92	16	NOTICE OF MOTION by Aetna Life Insurance, Aetna Health, Mutual of Omaha for preliminary injunction, Return date 10/26/92 (emil) [Entry date 09/01/92]
8/24/92	13	NOTICE OF MOTION by Aetna Life Insurance, Aetna Health for preliminary injunction, Return date 10/26/92 (emil)
8/31/92	15	MEMORANDUM by The Health Insurance, The Amer. Council, Life Insurance, Aetna Life Insurance, Aetna Health, Mutual of Omaha, Union Labor Life, Professional Ins. in support of [14-1] motion for summary judgment (emil) [Entry date 09/01/92]
8/31/92	17	MEMORANDUM by Aetna Life Insurance, Aetna Health, Mutual of Omaha in support of [16-1] motion for preliminary injunction (emil) [Entry date 09/01/92]
9/8/92	18	ANSWER by New York State Conf, Empire Blue Cross an (Attorney B.J. Costello, James J. Sabella) to amended complaint; by attorney Jane Lauer Barker for defendant Robert Abrams (emil)

10/2/92	22	NOTICE OF CROSS MOTION by New York State Conf, Empire Blue Cross an for summary judgment, Return date 10/26/92. Rule 3(g) statement in support is attached (emil)
10/2/92	23	AFFIDAVIT in support of Arthur B. Klein Re: [22-1] cross motion for summary judgment (emil)
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10/2/92	25	MEMORANDUM by New York State Conf, Empire Blue Cross an in opposition to pltffs' motion for a preliminary injunction (emil)
10/2/92	26	AFFIDAVIT in support of Jerry Weissman Re: [22-1] cross motion for summary judgment (emil)
10/2/92	27	AFFIDAVIT in support of Albert F. Antonini Re: [22-1] cross motion for summary judgment (emil)
10/15/92	28	STIPULATION and ORDER, that the Hospital Association of NY State be permitted to intervene as parties deft in this action with full rights of parties, including without limitation rights of appeal, to participate in oral argument and at trial, as well as to submit affidavits where appropriate, subject to the limitations listed in this stip and order (signed by Judge Louis J. Freeh). (emil)

10/16/92	29	Filed Memo-Endorsement on letter dated 10/8/92, NYSHMOC may intervene subject to the conditions stated herein (signed by Judge Louis J. Freeh) (emil) [Entry date 10/19/92]
10/19/92	30	MEMORANDUM by Mark Chassin, Mary Jo Bane, Salvatore R. Curiale, Robert Abrams in opposition to [13-1] motion for preliminary injunction, [16-1] motion for preliminary injunction (emil)
10/20/92	31	AFFIDAVIT in support of Kathryn Allen by The Health Insurance Re: [14-1] motion for summary judgment (emil)
10/20/92	32	MEMORANDUM by NYSHMOC in support of the motion for summary judgment of pltffs' Health Ins. Association of America and in reply to deft's motion for summary judgment (emil) [Entry date 12/28/92]
10/21/92	33	REPLY MEMORANDUM by Aetna Life Insurance, Aetna Health re: in support [14-1] motion for summary judgment and in opposition to cross-motions of defendants and intervenors. (emil) [Entry date 10/22/92]
10/26/92	34	REPLY by Aetna Life Insurance, Aetna Health, Mutual of Omaha Re: [13-1] motion for preliminary injunction (emil)
10/29/92	35	REPLY MEMORANDUM by New York State Confe, Empire Blue Cross an re: [22-1] cross motion for summary judgment (emil)

10/29/92	37	AFFIDAVIT of Jerry Weissman Re: in reply to the affidavits of Paul V. Bruno and Terence D. Tuohy (emil)
10/29/92	38	RESPONSE by New York State Conf, Empire Blue Cross an Re: pltffs' Health Ins. Association of America, statement purs. to Southern Dist, dated 10/21/92 (emil)
11/10/92	—	ORDER, consolidating this case with 92 cv 3999 (lead case) for all pretrial and trial purposes (signed by Judge Louis J. Freeh). For original entry see 92 cv 3999, doc. #53; Copies mailed (emil) [Entry date 11/12/92] [Edit date 11/12/92]
11/10/92	—	Consolidated Member Case. Lead Case Number: 1CV92 3999 (emil) [Entry date 11/12/92]

[For further docket entries see entries for 92 Civ. 3999 (LJF).]

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

93-7132L, 93-7134CON, 93-7148CON and 93-7194XAP

TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiff-Appellees,

NYS HEALTH MAINTENANCE ORGANIZATION CONFERENCE,

Plaintiff-Intervenor-Appellee,

against

MARIO CUOMO, in his Official Capacity as governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

2/17/93 Copy of district court docket entries and notice of appeal on behalf of Appellant Hospital Association filed. [93-7132] Form C due on 2/19/93. Form D due on 2/19/93. (com) [93-7132]

2/17/93 Copy of district court docket entries and notice of appeal on behalf of Appellant Mario Cuomo in 93-7134, Appellant Mark Chassin in 93-7134, Appellant Salvatore R. Curiale in 93-7134, Appellant Mary Jo Bane in 93-7134, Appellant Robert Abrams in 93-7134 filed. [93-7134] Form C due on 2/26/93. Form D due on 2/26/93. (com) [93-7134]

2/24/93 Copy of district court docket entries and notice of appeal on behalf of Appellants New York State Conf, Empire Blue Cross in 93-7148 filed. [93-7148] Forms C and D due on 3/5/93. (cop) [93-7148]

3/8/93 Copy of district court docket entries and notice of appeal on behalf of Appellee-Cross-Appellant Travelers Insurance in 93-7194 filed. [93-7194] Form C due on 3/15/93. Form D due on 3/15/93. (com) [93-7194]

3/17/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 brief RECEIVED. Problem: wrong color brief. (onl) [93-7132]

3/17/93 Joint appendix received. Number of volumes: 3. Problem: awaiting correction of brief. (onl) [93-7132]

3/18/93 Appellant-Cross-Appellee Hospital Association in 93-7132 brief FILED with proof of service. (disclosure statement attached to brief) (onl) [93-7132]

3/18/93 Appellants-Cross-Appellees Mario Cuomo, Mark Chassin, Salvatore R. Curiale, Mary Jo Bane, and Robert Abrams in 93-7134 brief FILED with proof of service. (onl) [93-7132]

3/19/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 brief FILED with proof of service. (disclosure statement attached to brief) (onl) [93-7132]

3/19/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7148 joint appendix filed w/pfs. Number of volumes: 3. (onl) [93-7132]

3/19/93 New party added: Secretary of Labor as *amicus curiae* on appeal. (unv) [93-7132]

3/19/93 *Amicus Curiae* Secretary of Labor in 93-7132 brief filed with proof of service. (unv) [93-7132]

3/30/93 *Amicus Curiae* State of Connecticut in 93-7132 brief filed with proof of service. (unx) [93-7132]

4/14/93 Appellees NYS Health Maint, MVP Health Plan, WellCare of New York, Mid-Hudson Health, Oxford Health Plan, Capital District, ChoiceCare LI, Independent Health, Travelers of NY, Physicians Health, Preferred Care, and U.S. Healthcare in 93-7132 brief filed with proof of service. (onl) [93-7132]

4/14/93 Appellee-Cross-Appellant Travelers Insurance, and Appellees Health Insurance, American Council, Life Ins. Council, Aetna Life Ins., Aetna Health Plans, Mutual of Omaha Ins., Union Labor Life Ins, and Professional Ins in 93-7132 oversized brief filed with proof of service. (onl) [93-7132]

4/16/93 *Amicus Curiae* USA in 93-7132 brief filed with proof of service. (unv) [93-7132]

4/28/93 Appellant-Cross-Appellee Hospital Association in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

4/28/93 Appellants-Cross-Appellees New York State Conf, and Empire Blue Cross in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

4/29/93 Appellants-Cross-Appellees Mario Cuomo, Mark Chassin, Salvatore R. Curiale, Mary Jo Bane, and Robert Abrams in 93-7132 reply brief filed with proof of service. Satisfy appellant's reply brief due. (onl) [93-7132]

5/17/93 Order FILED GRANTING motion to participate as *amicus* [383487-1] by Movant Natl Carriers' Conf, endorsed on motion form dated 4/14/93., GRANTING motion to file brief as *amicus curiae* [383487-2] by *Amicus Curiae* Natl Carriers' Conf, endorsed on motion form dated 4/14/93. (cal) [93-7132]

5/17/93 *Amicus Curiae* Natl Carriers' Conf in 93-7132 brief filed with proof of service. (cal) [93-7132]

5/17/93 Order FILED GRANTING motion to file brief as *amicus curiae* [383520-2] by Movant Electrical Industry, GRANTING motion to participate as *amicus* [383526-1] by Movant Electrical Industry, U.F.C.W. Funds, GRANTING motion to file brief as *amicus curiae* [383526-2] by *Amicus Curiae* Electrical Industry, U.F.C.W. Funds, endorsed on motion form dated 4/14/93. (cal) [93-7132]

5/17/93 *Amicus Curiae* Electrical Industry and U.F.C.W. Funds brief filed with proof of service. (cal) [93-7132]

5/20/93 Case heard before LUMBARD, CARDAMONE, MCLAUGHLIN, C.JJ (TAPE: 216+217) (car) [93-7132]

10/25/93 Judgment of the District Court, SDNY, is AFFIRMED in part and REVERSED in part by signed opinion FILED (JMCL). (onw) [93-7132]

10/25/93 Judgment filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellee Hospital Association in 93-7132 Petition for rehearing, with suggestion for rehearing *en banc* [457705-2] with proof of service filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellees Salvatore R. Curiale in 93-7134, Mark Chassin in 93-7134, and Mario Cuomo in 93-7134 Petition for rehearing [457921-1] with proof of service filed. (onw) [93-7132]

11/8/93 Appellant-Cross-Appellees Empire Blue Cross in 93-7148, and New York State Conference in 93-7148 Petition for rehearing, and petition for rehearing *en banc* [457978-2] with proof of service filed. (onw) [93-7132]

1/12/94 Order FILED GRANTING petition for REHEARING [457705-1] by Appellant-Cross-Appellee Hospital Association [457921-1] and by Appellant-Cross-Appellees Salvatore R. Curiale, Mark Chassin, Mario Cuomo, [457978-1] and by Appellant-Cross-Appellees Empire Blue Cross, New York State Conference. No additional briefing or oral argument is required. The panel will file an amended opinion forthwith. (onw) [93-7132]

1/14/94 Amended published signed opinion filed. (JMCL). (onw) [93-7132]

1/19/94 Appellant-Cross-Appellee Hospital Association motion for stay mandate pending application for a writ of certiorari FILED (w/pfs). [477805-1] (ono) [93-7132]

1/19/94 Appellant-Cross-Appellee Empire Blue Cross motion for stay of mandate and judgment pending application for a writ of certiorari. If stay is denied—a 3 business day extension of time before issuance of the mandate, to afford the parties an opportunity to request a stay from the Supreme Court FILED (w/pfs). [477813-1] (ono) [93-7132]

1/20/94 Appellant-Cross-Appellee Mario Cuomo motion for stay of mandate pending application for a writ of certiorari FILED (w/pfs). [477820-1] (ono) [93-7132]

1/20/94 Appellant-Cross-Appellee Mario Cuomo memorandum of law in support of motion for stay pending application to the Supreme Court for a writ of certiorari # [477820-1] by Appellant-Cross-Appellee Mario Cuomo filed. (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate and judgment pending application for a writ of certiorari [477813-1] by Appellant-Cross-Appellee Empire Blue Cross, endorsed on motion form dated 1/19/94. (JEL, RJC, JMcL, CJJ) (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate pending application for a writ of certiorari [477805-1] by Appellant-Cross-Appellee Hospital Association, of New York State endorsed on motion form dated 1/19/94. (JEl/RJC/JMcL, CJJ) (ono) [93-7132]

2/7/94 Order FILED GRANTING motion for stay of mandate pending application for a writ of certiorari [477820-1] by Appellant-Cross-Appellee Mario Cuomo, and all other state defendants endorsed on motion form dated 1/20/94. (ono) [93-7132]

3/7/94 Order FILED DENYING petitions for rehearing *en banc* [457705-2] by Appellants-Cross-Appellees NYS Conference of Blue Cross & Blue Shield Plans, Empire Blue Cross and Blue Shield, and Hospital Association of New York [457978-2]. (onw) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee Mario Cuomo in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1414. (ona) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee New York State Conf in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1408. (ona) [93-7132]

3/17/94 Notice of filing petition for writ of certiorari for Appellant-Cross-Appellee Hospital Association in 93-7132 dated 3.9.94 filed. Supreme Ct#: 93-1415. (ona) [93-7132]

IN THE SUPREME COURT OF THE UNITED STATES

Order Granting Writ of Certiorari, dated October 7, 1994

FRIDAY, OCTOBER 7, 1994

CERTIORARI GRANTED

93-1408) NY STATE CONF. OF BLUE CROSS V. TRAVELERS INSURANCE, ET AL.

93-1414) CUOMO, GOVERNOR OF NY, ET AL V. TRAVELERS INSURANCE, ET AL.

93-1415) HOSP. ASSOC. OF NY STATE V. TRAVELERS INSURANCE, ET AL.

The petitions for writs of certiorari in Nos. 93-1408 and 93-1414 are granted. The petition for a writ of certiorari in No. 93-1415 is granted limited to Question 1 presented by the petition. The briefs of petitioners are to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Wednesday, November 16, 1994. The briefs of respondents are to be filed with the Clerk and served upon opposing counsel counsel on or before 3 p.m., Tuesday, December 13, 1994. Reply briefs, if any, are to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Thursday, December 29, 1994. Rule 29.2 does not apply. The cases are consolidated and a total of one hour is allotted for oral argument.

IN THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Amended Opinion of United States Court of Appeals for the Second Circuit, dated January 14, 1994

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

Nos. 1514, 1515, 1516, 1667 August Term, 1992

(Argued: May 20, 1993 Decided: October 25, 1993)

Opinion Amended: Jan. 14, 1994

Docket Nos. 93-7132L, 93-7134CON, 93-7148CON, 93-7194XAP

THE TRAVELERS INSURANCE COMPANY,

Plaintiff-Appellee-Cross-Appellant,

HEALTH INSURANCE ASSOCIATION OF AMERICA, AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE CO., AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs-Appellees,

NEW YORK STATE HEALTH MAINTENANCE ORGANIZATION CONFERENCE AND HEALTH SERVICES MEDICAL CORPORATION, MVP HEALTH PLAN, WELLCARE OF NEW YORK, MID-HUDSON HEALTH PLAN, OXFORD HEALTH PLAN, CAPITAL DISTRICT PHYSICIANS HEALTH PLAN, CHOICECARE LONG ISLAND, INDEPENDENT HEALTH, TRAVELERS OF NEW YORK, PHYSICIANS HEALTH SERVICES, PREFERRED CARE and U.S. HEALTHCARE,

Plaintiffs-Intervenors-Appellees,

v.

MARIO M. CUOMO, in his official capacity as Governor of the State of New York, MARK CHASSIN, M.D., in his official capacity as Commissioner of Health for the State of New York, SALVATORE R. CURIALE, in his official capacity as Superintendent of Insurance of the State of New York, MARY JO BANE, in her official capacity as Commissioner of Social Services of the State of New York, ROBERT ABRAMS, in his official capacity as Attorney General of the State of New York,

Defendants-Appellants-Cross-Appellees,

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, EMPIRE BLUE CROSS AND BLUE SHIELD, HOSPITAL ASSOCIATION OF NEW YORK STATE,

Intervenors-Defendants-Appellants-Cross-Appellees.

Before: LUMBARD, CARDAMONE, and McLAUGHLIN, *Circuit Judges*.

Appeal and cross-appeal from a judgment of the United States District Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. The district court held, *inter alia*, that: (1) certain provisions of New York Public Health Law § 2807-c are preempted by ERISA, 29 U.S.C. §§ 1001-1461, and FEHBA, 5 U.S.C. §§ 8901-8914; and (2) ERISA also preempts parts of Actuarial Letter No. 5, issued by New York's Department of Insurance.

Affirmed in part; reversed in part.

M. PATRICIA SMITH, Ass't Attorney General, New York, NY (Robert Abrams, Attorney General of the State of New York, Jane Lauer Barker, Ass't Attorney General in Charge of Labor Bureau, New York, NY, of counsel), *for Defendants-Appellants-Cross-Appellees*.

ROBERT A. BICKS, New York, NY (James J. Sabella, Patricia Anne Kuhn, Breed Abbott & Morgan, New York, NY; Bartley J. Costello III, Eileen M. Considine, David J. Oakley, Hinman, Straub, Pigors & Manning, P.C., Albany, NY, of counsel), *for Intervenors-Defendants-Appellants-Cross-Appellees Empire Blue Cross & Blue Shield and The New York State Conference of Blue Cross & Blue Shield Plans*.

JEFFREY J. SHERRIN, Albany, NY (Philip Rosenberg, Sherrin & Glasel, Albany, NY, of counsel), *for Intervenor-Defendant-Appellant-Cross-Appellee Hospital Association of New York State*.

CRAIG P. MURPHY, New York, NY (Darrell M. Joseph, David B. Kostman, Windels, Marx, Davies & Ives, New York, NY; Clifford D. Stromberg, David Hensler, A. Lee Bentley, III, Hogan & Hartson, Washington, DC; David M. Ermer, Brad W. Spencer, Gordon & Barnett, Washington, DC, of counsel), *for Plaintiff-Appellee-Cross-Appellant The Travelers Insurance Company, and Plaintiffs-Appellees Health Insurance Association of America, American Council of Life Insurance, Life Insurance Council of New York, Inc., Mutual of Omaha Insurance Company, The Union Labor Life Insurance Company, Aetna Life Insurance Company and Aetna Health Plans of New York, Inc. and Professional Insurance Agents of New York, Inc. Trust*.

HAROLD N. ISELIN, Albany, NY (Barbara S. Brenner, Steve T. Engelman, Couch, White, Brenner, Howard & Feigenbaum, Albany, NY, of counsel), *for Plaintiffs-Intervenors-Appellees New York State Health Maintenance Organization Conference, Capital District Physicians' Health Plan, Inc., Choicecare Long Island, Inc., Health Services Medical Corporation of Central New York, Inc., Independent Health Association, Inc., Mid-Hudson Health Plan, Inc., Mohawk Valley Physicians' Health Plan, Inc., Oxford Health Plans, Inc., Physicians Health Services of New York, Inc., Preferred Care, Inc., Travelers Health Network of New York, Inc., U.S. Healthcare, Inc., and Wellcare of New York, Inc.*

Stuart E. Schiffer, Acting Ass't Attorney General, Washington, DC (Roger S. Hayes, U.S. Attorney, Anthony J. Steinmeyer, Scott R. McIntosh, Appellate Staff, Civil Division, Dep't of Justice, Washington, DC, of counsel), *filed a brief on behalf of the United States as Amicus Curiae*.

Susan M. Green, Trial Attorney, U.S. Dep't of Labor, Washington, DC (Judith E. Kramer, Deputy Solicitor of Labor, Marc I. Machiz, Associate Solicitor, Plan Benefits Security Division, Karen L. Handorf, Counsel for Decentralized and Special Litigation, Eric G. Serron, Trial Attorney, U.S. Dep't of Labor, Washington, DC, of counsel), *filed a brief on behalf of the Secretary of Labor as Amicus Curiae.*

Hugh Barber, Ass't Attorney General, Hartford, CT (Richard Blumenthal, Attorney General of the State of Connecticut, Richard J. Lynch, Arnold I. Menchel, Paul J. Lahey, Phyllis E. Hyman, Ass't Attorneys General, Hartford, CT, of counsel), *filed a brief on behalf of the State of Connecticut as Amicus Curiae.*

Benjamin W. Boley, Washington, DC, (William H. Dempsey, Shea & Gardner, Washington, DC, of counsel), *filed a brief on behalf of the National Carriers' Conference Committee as Amicus Curiae.*

Edward J. Groarke, Garden City, NY (Colleran, O'Hara & Mills, of counsel), *filed a brief on behalf of Trustees of and The Pension, Hospitalization Benefit Plan of the Electrical Industry and Trustees of and United Food and Commercial Workers Local 174 Health Care Fund, Trustees of and United Food and Commercial Workers Local 174 Retail Welfare Fund, and Trustees of and United Food and Commercial Workers Local 174 Commercial Health Care Fund as Amici Curiae.*

McLAUGHLIN, *Circuit Judge*:

Defendants Mario Cuomo *et al.* ("the State") and intervenors-defendants New York Conference of Blue Cross and Blue Shield Plans *et al.* appeal from a judgment of the United States District

Court for the Southern District of New York (Louis J. Freeh, *Judge*), granting plaintiffs' motions for summary judgment in part and denying defendants' motions and cross-motions for summary judgment. *Travelers Ins. Co. v. Cuomo*, 813 F. Supp. 996 (S.D.N.Y. 1993).

The district court held that certain components of New York's inpatient hospital reimbursement system are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992), and the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914 (1988 & Supp. IV 1992). In particular, the district court invalidated three subsections of New York Public Health Law § 2807-c (McKinney Supp. 1993) imposing surcharges on the hospital rates for certain categories of payors, and not others. The district court also held that ERISA preempts ¶¶ 1, 2, 3, and 5 of Actuarial Letter No. 5, issued by New York's Department of Insurance.

The Travelers Insurance Company ("Travelers") cross-appeals, contending that the district court should also have granted its motion for summary judgment as to ¶ 4 of the Actuarial Letter, as well. We agree with Travelers and reverse that portion of the judgment which held that ¶ 4 is not preempted by ERISA. In all other respects, we affirm.

BACKGROUND

Eighty-eight percent of non-elderly Americans have private health care insurance through their employee welfare benefit plans. ERISA is the governing statute. ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills and usually carries excess liability coverage known as "stop-loss" coverage; (3) subscription to a health maintenance

organization ("HMO"); and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans (the "Blues").

Whereas ERISA regulates employee benefit plans of private employers, FEHBA establishes a comprehensive program to provide federal employees, their families, and federal retirees (collectively, "enrollees") with subsidized health care benefits. Under FEHBA, the United States does not act as an insurer, but, through the Office of Personnel Management ("OPM"), contracts with various insurance carriers to develop health care plans with varying coverages and costs. 5 U.S.C. § 8902. Prospective enrollees can select coverage from any one of the participating carriers in their region. 5 U.S.C. § 8905. Among the numerous plaintiffs in this action, only Mutual of Omaha Insurance Company underwrites and administers a FEHBA health benefit plan covering federal enrollees who receive inpatient hospital care in New York.

Any patient entering a hospital is placed in a category known as a diagnosis-related group ("DRG"), based on his symptoms and probable cost of treatment. The amount the hospital may charge for the patient's care is based on the DRG, not the actual cost of treatment. New York law provides that the DRG amount charged to a particular patient is then increased by a "payor factor," depending on the type of health care coverage the patient has. This, of course, results in a "differential" in the charges, depending on which type of health care coverage the patient has.

Since its enactment in 1988, New York Public Health Law § 2807-c(1)(b) has required that insurance carriers of patients covered by any form of health plan other than the Blues, an HMO, or government insurance such as Medicaid must pay 13% above the DRG rate. The 13% differential, which is kept by the hospital, was enacted to contain hospital costs and to increase the availability of hospital insurance coverage to needy New

Yorkers. In particular, the differential was meant to " 'level [the] playing field' " for the Blues "in their competition with commercial insurers." Joint Appendix at 649; Clyne Aff. ¶ 15. The hope was that this would encourage more employers and ERISA plans to subscribe to the Blues.

The New York Omnibus Revenue Act of 1992 imposed two more surcharges: (1) an additional 11% surcharge on DRG payment rates charged to patients covered by commercial insurance, 1992 N.Y. Laws, ch. 55, § 348 (codified as amended at N.Y. Pub. Health Law § 2807-c(11)(i) (McKinney Supp. 1993)); and (2) an assessment of up to 9% on HMOs which fail to enroll a target number of Medicaid-eligible persons. 1992 N.Y. Laws, ch. 55, § 346 (codified as amended at N.Y. Pub. Health Law § 2807-c(2-a)(a) (McKinney Supp. 1993)). Unlike the basic 13% differential, the proceeds of the 11% surcharge are not kept by the hospital, but are paid into a statewide pool, which is then deposited into the State's general fund. HMOs, in contrast, must pay their 9% assessment directly into a statewide HMO pool, but it too ultimately winds up in the State's coffers.

The obvious effect of the 11% surcharge is to increase commercial insurers' costs of providing health care, thus making them less competitive with the Blues. Unlike the 11% surcharge, however, the primary purpose of the 9% assessment is to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program.

Besides imposing surcharges, New York's Department of Insurance has issued "Actuarial Information Letter No. 5," regulating how self-insured plans obtain "stop-loss" insurance. The Letter: (1) permits a self-insured to obtain stop-loss insurance only if the plan provides its members with statutorily mandated services; (2) requires that self-insured plans provide beneficiaries with the right to a statutory conversion policy; and (3) requires

self-insured plans to afford members various protections in case the plan becomes insolvent.

In separate actions, several commercial insurers and insurance industry trade associations, including Travelers and the Health Insurance Association of America ("HIAA"), sued various New York State authorities for declaratory and injunctive relief, complaining that all three surcharges and the Actuarial Letter are preempted by ERISA, and the 13% and 11% surcharges are also preempted by FEHBA. The New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield (collectively, the "Blues Conference"), and the Hospital Association of New York State ("HANYS") intervened as defendants; the New York State Health Maintenance Organization Conference and several HMOs intervened as plaintiffs. Thereafter, the parties cross-moved for summary judgment, and the district judge then consolidated the various actions.

The district court granted most of the relief that plaintiffs sought, holding that: (1) the Tax Injunction Act does not preclude an injunction against the 11% and 9% surcharges; (2) ERISA preempts all three surcharges; (3) FEHBA preempts the 13% and 11% surcharges; (4) plaintiffs' claims as to the 13% surcharge are not barred by the doctrine of laches; and (5) ¶¶ 1, 2, 3, and 5 of the Actuarial Letter are also preempted by ERISA. The court enjoined the defendants from enforcing the surcharges and the Actuarial Letter against the appropriate payors, but then stayed its ruling insofar as it enjoined the State from enforcing the 13% surcharge. Defendants appeal and plaintiff Travelers cross-appeals.

DISCUSSION

To promote clarity, we divide our analysis into four segments: (1) whether the district court had jurisdiction over these actions; (2) whether the equitable defense of laches raised by intervenor

HANYS has merit; (3) whether FEHBA preempts the 13% and 11% surcharges; and (4) finally, we address the chief argument advanced in support of reversal, ERISA preemption.

I. *Jurisdiction*

The Tax Injunction Act ("TIA") provides that federal district courts "shall not enjoin, suspend, or restrain the assessment . . . of any tax under State law where a plain, speedy and efficient remedy may be had in the courts of such State." 28 U.S.C. § 1341 (1988); *see Kraebel v. New York City Dep't of Hous. Preservation & Dev.*, 959 F.2d 395, 400 (2d Cir.) (TIA "bars federal injunctive challenges to state tax laws in federal courts."), *cert. denied*, 113 S. Ct. 326 (1992). This prohibition includes "declaratory as well as injunctive relief." *Barringer v. Griffes*, 964 F.2d 1278, 1280 (2d Cir. 1992).

The district court held that the TIA did not apply to the 11% and 9% surcharges, and therefore, it had jurisdiction. Two conditions must be satisfied to invoke the protection of the TIA: first, the surcharges must constitute "taxes,"[1] and second, the state remedies available to plaintiffs must be "plain, speedy and efficient." *See Kraebel*, 959 F. 2d at 400.

A. *Taxes*

The district court "assumed" that the 11% and 9% surcharges were "taxes" under the TIA, stating "to the extent that [these] [s]urcharges are paid into New York's General Fund, they appear to be taxes." 813 F. Supp. at 1000 & n.1 (citation omitted). Although there is no bright line between assessments that are taxes and those that are not, most courts agree that "[a]ssessments which are imposed primarily for revenue-raising purposes

[1]The Blues Conference does not argue that the 13% differential is a "tax" for good reason: its proceeds are retained by the hospitals and not deposited into the State treasury.

are 'taxes,' while levies assessed for regulatory or punitive purposes, even though they may also raise revenues, are generally not 'taxes.' " *Butler v. Maine Supreme Judicial Court*, 767 F. Supp. 17, 19 (D. Me. 1991) (collecting cases). In general, courts "have tended . . . to emphasize the revenue's ultimate use, asking whether it provides a general benefit to the public, of a sort often financed by a general tax, or whether it provides more narrow benefits to regulated companies or defrays the agency's costs of regulation." *San Juan Cellular Tel. Co. v. Public Serv. Comm'n*, 967 F.2d 683, 685 (1st Cir. 1992).

It is apparent that the 11% and 9% surcharges are taxes. Notwithstanding the primary purposes ascribed to the surcharges by the State, both raise revenue which is ultimately paid into the State's general fund. Thus, because the contested surcharges serve general revenue-raising purposes, they constitute "taxes" for purposes of the TIA. *See, e.g., Keleher v. New England Tel. & Tel. Co.*, 947 F.2d 547, 549 (2d Cir. 1991) (the word "tax" under the TIA "encompasses any state or local revenue collection device," including a city-assessed public utility "franchise fee" because the money raised was treated as part of the city's "general revenue"); *Butler*, 767 F. Supp. at 19 (nonrefundable jury fee required in Maine state courts "fits comfortably within [the] definition of a 'tax' under section 1341" because "the fees collected will be funneled into Maine's general fund, rather than being applied directly to the costs of jury trials.").

B. *State Remedy*

The district court found that plaintiffs did not have a "plain, speedy and efficient remedy" in New York state court "[b]ecause ERISA generally confers exclusive jurisdiction on the federal courts." 813 F. Supp. at 1001 (relying upon *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280, 1283 (D. Conn. 1977)). Plaintiffs sued here as plan fiduciaries to enjoin a practice violating ERISA. Congress has divested the

state courts of jurisdiction over such claims. *See* 29 U.S.C. § 1132(e)(1) (1988); *see also Shofer v. Hack Co.*, 970 F.2d 1316, 1319 (4th Cir. 1992) (where ERISA claims are within the exclusive jurisdiction of the federal courts, state courts are plainly without jurisdiction). Thus, "[b]ecause the [New York] courts lack the jurisdiction to decide the plaintiffs' injunctive and declaratory ERISA claims, the plaintiffs are without a 'plain, speedy and efficient' remedy at state law." *Thiokol Corp. v. Department of Treasury, Revenue Div.*, 987 F.2d 376, 380 (6th Cir. 1993); *accord E-Systems, Inc. v. Pogue*, 929 F.2d 1100, 1102 (5th Cir.) (TIA is "inapplicable" in an ERISA setting), *cert. denied*, 112 S. Ct. 585 (1991).

Accordingly, we conclude that the district court did not err in finding that the state remedies available to plaintiffs were inadequate, and thus it had jurisdiction over plaintiffs' claims.

II. *Laches*

New York's complex reimbursement system has had a differential among various payors since the late 1970s. A statutory differential has existed since 1983. Hence, intervenor HANYS contends that plaintiffs' current challenge to the 13% differential is barred by laches.

Laches is an equitable defense that applies when "a plaintiff unreasonably delayed in initiating an action and a defendant was prejudiced by the delay." *Robins Island Preservation Fund, Inc. v. Southold Dev. Corp.*, 959 F.2d 409, 423 (2d Cir.) (citations omitted), *cert. denied*, 113 S. Ct. 603 (1992). We review a district court's application of the laches doctrine for an abuse of discretion, *see King v. Innovation Books, Div. of Innovative Corp.*, 976 F.2d 824, 832 (2d Cir. 1992), and we find no abuse here.

In our view, there was a legitimate reason for plaintiffs' delay in mounting this challenge. *See Stone v. Williams*, 873 F.2d 620,

624 (2d. Cir.) ("[I]t is the reasonableness of the delay rather than the number of years that elapsed which is the focus of the [laches] inquiry."), *cert. denied*, 493 U.S. 959, *and vacated on other grounds*, 891 F.2d 401 (2d Cir. 1989), *cert. denied*, 496 U.S. 937 (1990). Almost ten years ago, in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985), we rejected a claim that ERISA preempted New York's regulatory scheme governing hospital rates.

Rebaldo, while probably distinguishable, created little hope for the success of future challenges to New York's reimbursement system. Prospects of success improved only recently because of Supreme Court cases which, as will be discussed *infra*, undermine *Rebaldo*. Immediately after *Rebaldo*, instead of challenging the 13% differential in court, plaintiffs changed their tactics and sought a legislative remedy, instead. Only when these legislative efforts failed in 1992 with the enactment of an additional 11% surcharge did they sue the State. This is not a tableau of unreasonable delay. Accordingly, we find no error in the district court's rejection of the laches defense.

III. *FEHBA Preemption*

Adopted as part of the Omnibus Budget Reconciliation Act of 1990 ("OBRA"), Pub. L. No. 101-508, § 7002(c), 104 Stat. 1388, 1388-330 (1990) (codified without title of § 7002(c) at 5 U.S.C. § 8909(f) (Supp. IV 1992) (amending 5 U.S.C. § 8909 (1988)), FEHBA's preemption provision is contained in § 8909(f)(1):

> No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

The district court found this provision ambiguous. Finding the statute's legislative history equally unenlightening, it invoked the teachings of *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984) (absent clear congressional intent, district courts should defer to implementing agency's interpretation of a federal statute, as long as that interpretation is reasonable). Thus, the court turned to OPM for guidance. It concluded that OPM's determination that the surcharges are preempted under § 8909(f)(1) was a reasonable construction of the statute and deferred to that interpretation by holding FEHBA preempted the 13% and 11% surcharges.

On appeal, defendants renew the argument that "the language of the statute as well as its legislative history are unambiguous, and reflect Congress' clear intent that FEHBA preemption apply only to state premium taxes." 813 F. Supp. at 1010; *see* 48 C.F.R. § 1652.216-71 (1992) (defining "premium taxes" as those "imposed on FEHB premiums by any State, the District of Columbia, or the Commonwealth of Puerto Rico"). They point to the statute's legislative history and the title of § 7002(c) -- "EXEMPTION FROM STATE PREMIUM TAXES" -- and conclude that § 8909(f)(1) is targeted only at premium taxes, and not the surcharges here. We are not persuaded.

We start by looking at the plain language of a statute to interpret its ordinary common meaning. *See Connecticut Nat'l Bank v. Germain*, 112 S. Ct. 1146, 1149 (1992) ("courts must presume that a legislature says in a statute what it means and means in a statute what it says"). "If the words of a statute are unambiguous, judicial inquiry should end, and the law interpreted according to the plain meaning of its words." *Aslanidis v. United States Lines, Inc.*, 7 F.3d 1067, 1073 (2d Cir. 1993). In our view, the language of § 8909(f)(1) is sufficiently clear to reveal congressional intent. *See Ardestani v. INS*, 112 S. Ct. 515, 520 (1991) (strong presumption that plain language of statute expresses legislative intent).

By its terms, 5 U.S.C. § 8909(f)(1) prohibits [1] every state or local "tax, fee, or other monetary payment" [2] imposed, "directly or indirectly," on a "carrier or an underwriting or plan administration subcontractor of an approved [FEHBA] health benefits plan," [3] "with respect to any payment made from the Fund." Defendants do not dispute that the 13% and 11% surcharges satisfy the first two requirements for preemption: the surcharges are a state-imposed "tax, fee, or other monetary payment," and they are imposed "directly or indirectly" on carriers offering FEHBA plans. The controversy, therefore, is over the third one -- the requirement that the tax is imposed "with respect to any payment made from the Fund."

Under FEHBA, the federal government and individual enrollees make "contributions" which are then deposited into the Employees Health Benefits Fund (the "Fund") in the United States Treasury. 5 U.S.C. §§ 8906, 8909 (1988 & Supp. IV 1992). The Fund is administered by OPM. *Id.*

OPM contracts with various insurance carriers, and through various health benefit plans the carriers provide, pay for, or reimburse the cost of health services for enrollees. 5 U.S.C. §§ 8901(6), 8901(7), and 8902(a) (1988). In turn, OPM creates a letter of credit ("LOC") account for each experience-rated plan,[2] and the LOC is maintained in the Treasury as part of the Fund. Each carrier draws against its LOC account on a "checks-presented" basis for amounts paid by the carrier as FEHBA claims or expenses. 5 U.S.C. § 8909(a) (Supp. IV 1992); 48 C.F.R. § 1632.170(b)(2) (1992). This requires carriers to pay for covered hospital treatment from their own resources, and then get reimbursed by drawing against their LOC. *Cf.* 48 C.F.R. § 1632.170(b)(2) ("[D]rawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment.").

[2]Contribution rates for an experience-rated plan are based on the plan's actual paid claims, administrative expenses, and other allowable "retentions." *See* 48 C.F.R. § 1602.170-6 (1992) (defining "[e]xperience rate"). In contrast, a "*[c]ommunity rate* means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan." 48 C.F.R. § 1602.170-2(a) (1992).

Because the FEHBA preemption issue in this case involves only experience-rated plans, we need not reach the issue as to community-rated plans.

Given this scheme of payment and reimbursement, and mindful of how the two reserves required for each experience-rated plan work, *see* 5 U.S.C. § 8909(b)(2) (Supp. IV 1992); 5 C.F.R. §§ 890.503(c)(1)-(2) (1993) ("contingency" reserve); 5 C.F.R. § 890.503(c)(3) (1993) ("carrier" reserve), the preemption issue is not a difficult one. The 13% and 11% surcharges are, indeed, imposed "with respect to any payment made from the Fund" because the amount drawn by experience-rated carriers from their LOC accounts, which are part of the Fund, is based in part on the amount of the surcharge. As already noted, carriers first pay hospital bills from their own funds, then draw from their LOC accounts to replenish their depleted funds. Because payments from the Fund are directly affected by what the hospitals charge for their services, and because the surcharges increase the amounts carriers draw from the Fund, the surcharges are clearly imposed "with respect to . . . payment[s] made from the Fund." Accordingly, they are preempted.

Despite this straightforward construction of § 8909(f)(1), defendants urge us to reject it because our interpretation is repugnant to the general aims of FEHBA. They believe that there is a clearly expressed legislative intention that is contrary to the language of the statute. *Cf. United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242 (1989) ("The plain meaning of legislation should be conclusive, except in the 'rare cases [in which] the literal application of a statute will produce a result demonstrably at odds with the intentions of its drafters.' " (citation omitted)).

In plumbing the legislative history of § 8909(f)(1), defendants selectively ignore legislative policies that run counter to their interpretation of the statute. Section 8909(f)(1) was enacted as part of OBRA, the central purpose of which was to reduce government expenditures. *See* H. Rep. No. 101-881, 101st Cong., 2d Sess. 169 (1990), *reprinted in* 1990 U.S.C.C.A.N. 2017, 2177. For its part, § 8909(f)(1) was designed to reduce expenditures from the Fund by preventing states from charging taxes on health care reimbursements drawn by carriers from the Fund. *Id.* at 173, *reprinted in* 1990 U.S.C.C.A.N. at 2181. To adopt defendants' crabbed view of preemption would undermine this revenue-saving purpose.

Defendants cite numerous excerpts from congressional committee reports where § 8909(f)(1) is characterized as a restriction on "premium taxes." This exercise is singularly unenlightening, however, because it remains obscure what the various members of Congress meant when they referred to "premium taxes" in discussing § 8909(f)(1). We also note that defendants' reliance on the title to § 7002(c) of OBRA containing § 8909(f) as an amendment to FEHBA is misplaced. Defendants simply ignore that the focal point of this controversy is FEHBA § 8909(f)(1), and not OBRA § 7002(c).

Finally, defendants are piqued that the district court deferred to OPM's current interpretation of the preemption issue. (This interpretation is set forth in the government's *amicus* brief and affidavits, and was first solicited by the State from OPM (in opinion letters) before this action even began.) Defendants argue that the district court ignored an earlier OPM regulation limiting the scope of § 8909(f) to "premium taxes," 48 C.F.R. § 1631.205-41 (1992), and instead improperly deferred to OPM's current interpretation which defendants characterize as " 'agency litigating positions that are wholly unsupported by regulations, rulings, or administrative practice.' " State's Brief at 44 (quoting *Bowen v. Georgetown University Hospital*, 488 U.S. 204, 212 (1988)).

Even if we agreed that the language of § 8909(f)(1) is ambiguous and its legislative history unilluminating, we would still affirm the district court's judgment, with its reliance on OPM's *amicus* position. As a preliminary matter, the district court did not defer to an "agency litigating position"; rather, it deferred to OPM's administrative interpretation of § 8909(f)(1), made before the government entered this litigation and offered in response to a request from New York itself.

OPM in its *amicus* brief to this Court asserts that 48 C.F.R. § 1631.205-41 uses "premium taxes" as a shorthand description of the taxes covered by 5 U.S.C. § 8909(f)(1), not in the narrow sense urged by defendants. The regulation stresses, in OPM's view, the broad sweep of § 8909(f), interpreting it to apply to "*all* payments directed by States or municipalities, regardless of how they may be titled, to whom they must be paid, or the purpose for which they are collected," including "*all* forms of direct and indirect measurement of FEHBP premiums, *however modified* . . . ." 48 C.F.R. § 1631.205-41 (emphasis added). Like the district court, we too will defer to OPM's interpretation of its own regulation unless it "is . . . plainly erroneous or inconsistent with the language of the regulation." *Federal Labor Relations Auth. v. United States Dept. of Veterans Affairs*, 958 F.2d 503, 514 (2d Cir. 1992) (citing *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989)). We cannot say it is unreasonable to interpret § 1631.205-41 as OPM does.

Accordingly, the New York statutes imposing the 13% and 11% surcharges are preempted by FEHBA.

IV. *ERISA Preemption*

Whether a particular state statute is preempted by ERISA is a question of statutory interpretation, as informed by congressional intent. With understated irony, the Supreme Court has described the ERISA section at issue here as "not a model of legislative

drafting." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). In truth, it is a veritable Sargasso Sea of obfuscation:

> **(a) Supersedure; effective date**
>
> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . .
>
> **(b) Construction and application**
>
> . . . .
>
> (2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities.
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be *deemed* to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. § 1144(a)-(b)(2)(B) (1988) (emphasis added).

The opening paragraph is the *preemption* clause. The next paragraph [(b)(2)(A)] is the *saving* clause. And the final paragraph [(b)(2)(B)] has come to be known as the *deemer* clause. *See FMC Corp. v. Holliday*, 498 U.S. 52, 57-58 (1990).

Setting sail, we begin with the observation that ERISA is a comprehensive federal statutory scheme regulating "private employee benefits plans, including both pension and welfare plans." *District of Columbia v. Greater Wash. Bd. of Trade*, 113 S. Ct. 580, 582 (1992). "A 'welfare plan' is defined . . . to include, *inter alia*, any 'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through the purchase of insurance or otherwise.' " *Id.* (quoting 29 U.S.C. § 1002(1)). While the statute does not mandate particular benefits, it " 'sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for . . . welfare plans.' " *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (quoting *Shaw v. Delta Air Lines. Inc.*, 463 U.S. 85, 91 (1983) (citation omitted)).

ERISA expressly preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by the statute. 29 U.S.C. § 1144(a) (the preemption clause). This sweeping provision is not without qualification and, pertinent to this case, excepts from preemption those state laws that "regulate insurance," 29 U.S.C. § 1144(b)(2)(A) (the saving clause), except as further provided in the deemer clause, stating that an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or "engaged in the business of insurance . . . for purposes of any [state law] purporting to regulate" insurance companies or insurance contracts. 29 U.S.C. § 1144(b)(2)(B); *see FMC Corp.*, 498 U.S. at 58.

The district court concluded that all the surcharges, as well as ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" employee benefit plans within the meaning of ERISA's preemption clause. The court also found that the surcharges are not preserved by the saving clause as laws that "regulate insurance;" and, without

considering whether the Actuarial Letter regulates insurance, the court also concluded that the deemer clause precluded any state regulation of self-funded plans. Accordingly, the district court held that ERISA preempted the three surcharges and also ¶¶ 1, 2, 3, and 5 of the Actuarial Letter. For the reasons set forth below, we substantially agree.

The Supreme Court has "repeatedly stated that a law 'relate[s] to' a covered employee benefit plan for purposes of [the preemption clause] 'if it has a connection with or reference to such a plan.' " *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97) (citations omitted). The term "relate to" is to be accorded "its broad common-sense meaning," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47 (1987), thereby giving "effect to the 'deliberately expansive' language chosen by Congress." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Pilot Life*, 481 U.S. at 46). "Under this 'broad common-sense meaning,' a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans or the effect is only indirect," *Ingersoll-Rand*, 498 U.S. at 139, and even if the law is "consistent with ERISA's substantive requirements." *Metropolitan Life Ins.*, 471 U.S. at 739. Accordingly, we have held that "a state law of general application, with only an indirect effect on a pension plan, may nevertheless be considered to 'relate to' that plan for preemption purposes." *Smith v. Dunham-Bush Inc.*, 959 F.2d 6, 9 (2d Cir. 1992).

On the other hand, the Court has also recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan," *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 100 n.21 (1983), "as is the case with many laws of general applicability." *Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 n.1. *See, e.g., Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1988) (generally applicable garnishment law under which creditors can garnish ERISA welfare benefits not preempted); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987)

(law requiring companies to make lump-sum severance payments when closing a plant not preempted); *Aetna Life Ins. Co. v. Borges*, 869 F.2d 142 (2d Cir.) (application of escheat law to ERISA-covered benefit checks and drafts issued but not collected or presented for payment by beneficiaries not preempted), *cert. denied*, 493 U.S. 811 (1989).

On appeal, defendants contend that "the [s]urcharges do not 'relate to' ERISA plans within the meaning of ERISA's preemption clause because they are laws of general application, which have only a peripheral impact on the plans." 813 F. Supp. at 1005. In making this argument, defendants rely on *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985) and fault the district court for its conclusion that *Rebaldo* "has been abrogated by later Supreme Court cases." 813 F. Supp. at 1005.

Rebaldo held that ERISA did not preempt certain New York regulations governing the right of self-insured employee benefit plans to negotiate discounts with hospitals. In rejecting this challenge, we initially found that "a state law must '*purport*[] to regulate, . . . the terms and conditions of employee benefit plans' to fall within the preemption provision" of ERISA. *Rebaldo*, 749 F.2d at 137 (quoting 29 U.S.C. § 1144(c)(2)) (emphasis added). *Rebaldo* went on to hold that the impact of New York's regulations on ERISA benefit plans was too tenuous, remote, and peripheral to require preemption. *Id.* at 138. Six years later, in *Ingersoll-Rand*, 498 U.S. at 141, the Supreme Court expressly rejected the notion that Congress intended to limit ERISA's preemptive effect to state laws *purporting* to regulate plan terms and conditions. *See Smith*, 959 F.2d at 9 & n.3 (following *Ingersoll-Rand*, rejecting "purports to regulate" standard). Despite *Ingersoll-Rand*, defendants continue to argue that *Rebaldo*'s analysis of what triggers ERISA preemption is still controlling.

We have little difficulty agreeing with the district court that *Rebaldo*'s fundamental premise was rejected by the Supreme Court. In our view, *Rebaldo*'s entire analysis is poisoned by its

discredited belief that ERISA's preemption clause is targeted only at state laws that "purport to regulate" plan terms and conditions. Therefore, we conclude that defendants' reliance on *Rebaldo* is misplaced.

A. *The Surcharges: Preemption*

Defendants maintain that the district court erred in concluding that the challenged statutes' indirect economic impact upon ERISA plans was substantial and impermissibly affected the structure, the administration, or the type of benefits furnished by a plan. We disagree. While the challenged statutes do not refer to ERISA plans, *see Mackey*, 486 U.S. at 831 (statute need not specifically mention ERISA plans to be preempted), our examination of the surcharges indicates that they satisfy the less stringent "connection with" standard embraced in *Ingersoll-Rand*.

The 13% and 11% surcharges are designed to increase hospital costs for patients covered by health plans other than the Blues, and thus make these competing plans less attractive than the Blues. Obviously, the surcharges will affect ERISA plans' health care benefits. Likewise, the 9% assessment imposed on HMOs will interfere with a plan's selection of the most effective method to provide benefits. Thus, the surcharges purposely interfere with the choices that ERISA plans make for health care coverage. Such interference is sufficient to constitute "connection with" ERISA plans. *See, e.g., National Elevator Indus., Inc. v. Calhoon*, 957 F.2d 1555, 1561 (10th Cir.) (ERISA preempts administrative interpretation of Oklahoma's prevailing wage statute insofar as it determines rates of pay and "may be used to effect change in the administration, structure and benefits of an ERISA plan"), *cert. denied*, 113 S. Ct. 406 (1992); *In re Michigan Carpenters Council Health & Welfare Fund*, 933 F.2d 376, 382-83 (6th Cir.) (ERISA preempts Michigan state corporate reorganization statute that allows employers unilaterally to alter their obligation to ERISA plans), *cert. denied*, 112 S. Ct. 585 (1991); *National Carriers' Conference Comm. v. Heffernan*, 440 F. Supp. 1280 (D. Conn. 1977) (Connecticut tax on ERISA benefits preempted since it

may encourage use of traditional insurance rather than ERISA-covered plans); *Morgan Guar. Trust Co. v. Tax Appeals Tribunal of Dep't of Taxation & Finance*, 80 N.Y.2d 44, 51, 587 N.Y.S.2d 252, 256, 599 N.E.2d 656, 660 (1992) (New York real estate gains tax preempted as applied to sale of ERISA property because tax will influence plans' investment strategy).

The surcharges substantially increase the cost to ERISA plans of providing beneficiaries with a given level of health care benefits. Under similar circumstances, the Fifth Circuit held that a state statute imposing a 2.5% tax on administrative and service fees was preempted by ERISA. *E-Systems, Inc. v. Pogue*, 929 F.2d 1100 (5th Cir.), *cert. denied*, 112 S. Ct. 585 (1991). The court found that the tax was related to ERISA plans because: "The cost of the plan must therefore increase for the employer and/or employees or the benefits must be adjusted downwards to offset the tax bite. This is the type of impact Congress intended to avoid when it enacted the ERISA legislation." *Id.* at 1103.

As in *E-Systems*, the surcharges here force ERISA plans to increase either plan costs or reduce plan benefits. Therefore, they have the requisite connection to ERISA. *See also General Electric Co. v. New York State Dep't of Labor*, 891 F.2d 25, 28 (2d Cir. 1989) (New York Labor Law governing wage requirements was preempted where it required employers to pay certain benefits, because " 'private parties, not the Government, control the level of benefits' " under ERISA) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981)), *cert. denied*, 496 U.S. 912 (1990); *cf. Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991) ("Like all the factors considered, . . . simply because the existence of some economic impact is not dispositive of the preemption issue does not make this factor irrelevant to the preemption inquiry."), *cert. denied*, 112 S. Ct. 2305 (1992).

In making its finding that the surcharges are related to ERISA, the district court focused on plaintiffs' claims that they would pass along the higher costs associated with the surcharges, which

might in turn lead plans to reduce their level of service or benefits. Defendants and the Department of Labor as *amicus* contend that the indirect and inevitably speculative economic impact of the challenged statutes *alone* does not justify a finding of preemption. They argue that the Supreme Court has never held that indirect economic impact, standing alone, is sufficient to justify a finding of preemption. *See, e.g., Mackey*, 486 U.S. at 830-41 (indirect economic effect of state garnishment law not enough to warrant preemption); *see also Aetna Life*, 869 F.2d at 146 ("where a state statute of general application 'does not affect the structure, the administration, or the type of benefits provided by an ERISA plan, the mere fact that the statute has some economic impact on the plan does not require that the statute be invalidated.' " (quoting *Rebaldo*, 749 F.2d at 139)).

The Blues Conference, in particular, relies on *NYSA-ILA Medical & Clinical Servs. Fund v. Axelrod*, No. 92 Civ. 2779 (JSM), 1993 WL 51146, at *4 (S.D.N.Y. Feb. 23, 1993) ("The tax is not great enough to pose a serious economic threat to the plan which might trigger preemption."). There, Judge Martin rejected an ERISA plan's challenge to New York's Health Facility Assessment ("HFA") because its economic impact on the plan was *de minimis*. The court distinguished *Morgan Guaranty Trust*, 80 N.Y.2d 44, 587 N.Y.S.2d 252, 599 N.E.2d 656, on the ground that the New York case involved a "substantial" tax of 10% of the consideration received for the realty sold therein, as opposed to the HFA of 0.6% of gross receipts to which the HFA was applicable. Further, Judge Martin in *NYSA-ILA* explicitly compared the result Judge Freeh reached in this case, with its surcharges of 13%, 11%, and 9% on hospital DRGs. *See NYSA-ILA*, 1993 WL 51146, at *4. Thus, the *NYSA-ILA* court recognized that a *substantial* economic impact, standing alone, could be enough to bring ERISA's preemption clause into play.

In sum, Judge Freeh properly found that the three surcharges "relate to" ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration.[3] Accordingly, the statutes at issue here are preempted -- unless they are salvaged by ERISA's saving clause as a law that regulates insurance. 29 U.S.C. § 1144(b)(2)(A).

B. *The Surcharges: Saving Clause*

To determine whether a state law regulates insurance within the meaning of the saving clause, a court must first "consider the

[3]To the extent that our holding conflicts with *United Wire, Metal & Machine Health & Welfare Fund v. Morristown Memorial Hosp.*, 995 F.2d 1179 (3rd Cir.), *cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 382, *and cert. denied*, 114 S. Ct. 383 (1993), we decline to follow it. In that case, several self-insured union employee welfare benefit plans sued numerous New Jersey hospitals and various New Jersey State authorities for injunctive relief, complaining that New Jersey's statutory scheme for setting hospital rates was preempted by ERISA. The rate-setting statute at issue imposed additional surcharges on DRG rates to compensate hospitals for providing "uncompensated care" and treating Medicare patients, and granted discounts to certain classes of payors.

The Third Circuit held that the rate-setting statute "does not relate to the plans in a way that triggers ERISA's preemption clause." *Id.* at 1191. In brief, the court found that the connection between the statute and ERISA plans was too tenuous and remote "[b]ecause we are here dealing with a statute of general applicability that is designed to establish the prices to be paid for hospital services, which does not single out ERISA plans for special treatment, and which functions without regard to the existence of such plans," *id.* at 1192, and the statute's "indirect ultimate effect of increasing plan costs" places it beyond the scope of ERISA preemption. *Id.* at 1193-95.

Ironically, in reaching its conclusion, the Third Circuit relied heavily on our opinion in *Rebaldo v. Cuomo*, 749 F.2d 133 (2d Cir. 1984), *cert. denied*, 472 U.S. 1008 (1985). As we discuss above, however, we believe that decisions of the Supreme Court since *Rebaldo* have significantly eroded the premise upon which *Rebaldo* was decided. More generally, however, we also believe that the Third Circuit reads ERISA's preemption clause too narrowly. *See United Wire*, 995 F.2d at 1196-1203 (Nygaard, J., dissenting).

'common-sense view' of the term 'regulates insurance' which suggests that 'in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be *specifically* directed toward that industry." *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158 (2d Cir. 1990) (quoting *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987)). The court must next assess whether the law satisfies the three criteria developed for determining whether a practice constitutes "the business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1988 & Supp. IV 1992).[4] *See Pilot Life*, 481 U.S. at 48. Those criteria are: " '*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' " *Id.* at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982)).

Applying these tests, we conclude, first of all, that the 13% and 11% surcharges do not "regulate insurance" within the meaning

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[4]The McCarran Act was enacted in 1945 to help resolve federalism concerns over the roles of federal and state governments in regulating insurance. Now known as the McCarran-Ferguson Act, it provides, in relevant part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That [the Sherman Act, the Clayton Act, and the Federal Trade Commission Act] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

of the saving clause.[5] Our common-sense inquiry reveals that these surcharges are not specifically directed toward the insurance industry; rather, they aim to regulate hospital rates. Although the surcharge laws provide for different payment rates based on whether a patient is uninsured, covered by an HMO, a commercial insurer or a self-insured health plan, they do not address matters typically within the purview of state insurance regulations such as: the solvency and qualification of an insurance company's management, the sale and advertising of insurance, rates and the content of insurance policies. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 727-28 & n.2 (1985).

Defendants argue that the 13% and 11% surcharges are designed to affect the insurance marketplace by giving the Blues a

[5]The Department of Labor ("DOL") argues that the saving clause validates all three surcharges; the Blues Conference argues that it preserves the 13% and 11% surcharges; and the State invokes it only as to the 11% surcharge. Although both the DOL and the Conference claim that HMOs are insurers for purposes of the saving clause, only the DOL contends that the 9% assessment on HMOs comes within ERISA's saving clause. The DOL argues that HMOs are engaged in the "business of insurance" when they reimburse hospitals for providing services to their subscribers. While HMOs must comply with certain provisions of the insurance law by virtue of the public health law, *see, e.g.*, N.Y. Pub. Health Law §§ 4402(2)(f) and 4406(1) (McKinney 1985) (superintendent of insurance required to review HMO subscriber contracts); N.Y. Pub. Health Law § 4409(2) (McKinney 1985) (superintendent required to examine each HMO's financial affairs periodically), New York law does not require HMOs to be state--licensed insurers. N.Y. Ins. Law § 1109(a) (McKinney 1985 & Supp. 1993). Nor can HMOs include in their names "words generally regarded as descriptive of the insurance function." N.Y. Pub. Health Law § 4411 (McKinney 1985). These latter provisions support the district court's finding that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law." 813 F. Supp. at 1007.

competitive advantage over commercial insurers, self-insured funds, and a number of other players in the marketplace -- and thus may be characterized as the regulation of insurance. This argument, however, confuses laws regulating the "business of insurance" with laws regulating hospital rates that have an effect on the "insurance marketplace." Although the surcharge laws clearly have some impact on insurance companies, this alone is not enough. As the Supreme Court has made clear in interpreting § 2(b) of the McCarran-Ferguson Act, there is a difference between the "business of insurance" and the "business of insurers." *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979).

In our view, defendants' arguments proceed from an impermissibly broad reading of the saving clause. Congress intended that ERISA's preemption provision would clear the field of any state law interfering with benefit plans, *see, e.g., FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990); *Pilot Life*, 481 U.S. at 47-48, and installed the saving clause to preserve only those state laws precisely directed at the insurance business. The more expansively the saving clause is read, the more deeply it cuts into the preemption. a result that would render the entire scheme unworkable.

Nor do the McCarran-Ferguson factors suggest otherwise. The Blues -- unlike commercial carriers -- offer health insurance to anybody, no matter who they are or what physical shape they are in. As the insurer of last resort, the Blues insure persons and groups that are, on the whole, older and less healthy, and therefore constitute unacceptably high risks for other insurers. Most high risk policyholders, therefore, are insured under the Blues. Because the 13% and 11% surcharges are designed to encourage ERISA plans -- with generally healthier persons -- to shift to the Blues, the State's reimbursement system would help spread the risk of health care costs.

Group Life & Health Insurance Co. v. Royal Drug Co., 440 U.S. 205 (1979), does not alter this conclusion. There, the Supreme Court ruled that Blue Shield's arrangement with certain pharmacies to charge Blue Shield's insureds only $2 for every prescription drug did not constitute the "business of insurance" under McCarran-Ferguson. As noted by the district court here, "[t]he Supreme Court held that the agreements between Blue Shield and the participating pharmacies did not spread any risk because those agreements merely reduced Blue Shield's costs for fulfilling an obligation which Blue Shield had already assumed." 813 F. Supp. at 1008 n.15 (citing *Royal Drug*, 440 U.S. at 212-14). Here, the challenged surcharges do not merely raise the cost of inpatient hospital services, but play a significant role in encouraging ERISA plans to shift to the Blues. Thus, unlike *Royal Drug*, the surcharges here can be said to have "the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48 (quoting *Union Labor Life Ins.*, 458 U.S. at 129).

The 13% and 11% surcharges, however, fail to satisfy the remaining two McCarran-Ferguson factors. These surcharges do not regulate any practice that is integral to the insurer-insured relationship. As we noted on an earlier occasion, the essence of the second McCarran-Ferguson factor is whether a statute "dictate[s] any of the terms of the insurance contract itself, the principal embodiment of the insurer-insured relationship." *Howard*, 901 F.2d at 1159. True, the surcharges here were designed to induce ERISA plans to switch their hospital coverage from commercial insurers to the Blues; but they do not directly change any of the terms, conditions or scope of coverage in commercial insurance contracts. Rather, because the surcharges expressly regulate hospital rates, they relate only to the contractual obligations between hospitals and insurers or insureds, but do not directly implicate the policy relationship between insurers and their insureds.

Finally, the surcharges are not "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 49 (quoting *Union Labor Life Ins.*, 458 U.S. at 129). In *Howard*, a provision of the New York Insurance Law required that either the insurer or the employer (in certain circumstances) give notice of conversion privileges upon termination of employment. *Id.* at 1156. We found that this provision was not a regulation of insurance. *Id.* at 1159. We noted that since the notice could be given by either the employer or the insurer, the law was not limited to entities within the insurance industry. *Id.* Here, the surcharges set rates that hospitals must charge patients, and thus involve entities beyond the insurance industry, including: the State, hospitals, patients, HMOs, and self-insured funds. Thus, the third McCarron-Ferguson factor is not satisfied.

Accordingly, because of our common-sense determination that the surcharges do not regulate insurance, and because two of the three McCarran-Ferguson factors are not satisfied, we agree with the district court that the 13% and 11% surcharges are not preserved by the saving clause. Accordingly, the New York statutes imposing the surcharges are preempted by ERISA.[6]

C. *The Actuarial Letter*

Self-insured employee benefit plans and their employer sponsors, including the Sheridan Catheter Plan (on whose behalf Travelers challenges the Actuarial Letter), often purchase stop-loss insurance to protect themselves against excess or catastrophic losses. Unlike traditional group-health insurance, stop-loss insurance is akin to reinsurance in that it does not provide coverage directly to plan members or beneficiaries. Rather, most

[6]We also agree with the district court that the 9% assessment does not "fall within the scope of the savings clause because HMOs . . . do not engage in the 'business of insurance' as a matter of law," 813 F. Supp. at 1007, and is thus preempted by ERISA. *See* discussion *supra* note 4.

stop-loss policies (and the policy issued to the Sheridan Catheter Plan here) provide coverage to the plan itself if the total amount of claims paid by the plan exceeds the amount of anticipated claims by a specified sum.

The Actuarial Letter under attack purports to regulate the terms of such stop-loss insurance contracts. Its relevant provisions follow:

> 1. The insurer must undertake to ensure that statutorily mandated benefits be covered under the employer's plan;
>
> 2. The insurer must agree to ensure that statutory conversion policies be provided, either by them or by another insurer;
>
> 3. Notice must be given to employees if and when the insurer becomes liable for runoff claims. . . .
>
> 4. The insurer should maintain full runoff reserves. If the policyholder holds his own reserves, the insurer's claim reserves are to be replaced by a terminal premium payable immediately upon termination. . . .
>
> 5. The insurer must take full responsibility for the payment of all employer plan claims incurred but not yet paid at the date of termination of the policy . . .

The district court properly found that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter "relate to" an employee benefit plan for purposes of ERISA's preemption clause. Paragraphs 1 and 5 on their face make specific "reference to" an employee benefit plan, and ¶¶ 2 and 3 clearly have a "connection with" such plans. *See Greater Wash. Bd. of Trade*, 113 S. Ct. at 583 (quoting *Shaw*, 463 U.S. at 97). ERISA therefore preempts ¶¶ 1, 2, 3, and 5 of the

Actuarial Letter unless they find salvation in ERISA's saving clause as a law that regulates insurance, and even that salvation will be denied unless the employee benefit plan can escape the orbit of § 1144(b)(2)(B) refusing to deem such a plan "to be an insurance company or other insurer."

The district court concluded that ¶¶ 1, 2, 3, and 5 were preempted and the saving clause for insurance regulations did not save them because, under the deemer clause, self-insured employee benefit plans are not deemed to be "an insurance company or other insurer . . . ." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). The Department of Labor and Travelers, while agreeing with this result, suggest that the district court should not have reached the deemer clause without first considering whether ¶¶ 1, 2, 3, and 5 regulate insurance at all, within the meaning of the saving clause. We agree. Accordingly, we affirm the district court's holding on a different ground: ¶¶ 1, 2, 3, and 5 are not saved from preemption because those paragraphs do not regulate insurance within the meaning of the saving clause.

As already discussed, in order to fall within the saving clause, the state law must constitute the regulation of insurance from a common-sense point of view and must also satisfy the McCarran-Ferguson factors. *See Pilot Life*, 481 U.S. at 48-49. The challenged provisions of the Actuarial Letter do neither.

Pilot Life's common-sense test does not validate every conceivable restriction on the sale of insurance contracts under the rubric of regulation of insurance. *See Howard*, 901 F.2d at 1158. We conclude that ¶¶ 1, 2, 3, and 5 of the Actuarial Letter use the regulation of stop-loss coverage as a pretext to regulate the terms of self-funded ERISA plans.

In ¶ 1 of the Actuarial Letter, the State permits a self-insured plan to obtain stop-loss coverage only if the plan provides its members and beneficiaries with the full panoply of benefits

mandated by New York's Insurance Law. Paragraph 2 requires the plan to provide its beneficiaries with the right to a statutory conversion policy. Paragraphs 3 and 5 require the plan to afford its members a host of protections in case the plan becomes insolvent. Because the conditions imposed by the Actuarial Letter are not limited just to the stop-loss layer of insurance but apply generally to the entire plan, we conclude that ¶¶ 1, 2, 3, and 5 of the Letter do not, as a practical matter, regulate just insurance.

Furthermore, the challenged provisions of the Actuarial Letter do not satisfy the McCarran-Ferguson criteria. First of all, ¶¶ 1, 2, 3, and 5 do not have the effect of transferring or spreading risk between a self-funded plan and its stop-loss insurer but, instead, require the self-insured plan to provide additional benefits and protections to the plan's members and beneficiaries.

Second, the challenged provisions are not an integral part of a self-funded plan's relationship with its stop-loss insurer. Paragraph 1, for example, focuses squarely on the self-funded plan's relationship with its participants, not with the stop-loss insurer. Because employees are not insured under the terms of the stop-loss policy, requiring the stop-loss insurer to notify such individuals, as ¶ 3 does, is not an integral part of the insurance relationship. Likewise, because ¶ 5's purpose is to protect employees, who are not insured under the stop-loss contract, that paragraph is not an integral part of the insurance relationship between the plan and its stop-loss insurer.

Finally, ¶¶ 1, 2, 3, and 5 are not limited to insurance entities. Paragraph 1 is aimed directly at sponsors of self-funded plans. By requiring the sponsoring employer to provide conversion rights through another insurer if the stop-loss insurer does not provide such rights, ¶ 2 is aimed directly at employers who are not part of the insurance industry. *See Howard*, 901 F.2d at 1159 (state law requiring either insurer or employer to notify covered employees of conversion rights was not "limited to entities within the insur-

ance industry"). Likewise, ¶ 3 states specifically that the Department of Insurance "will accept a policy provision which requires the employer to pass along [the notice] material." Thus, it too is not "limited to entities within the insurance industry." *See id.*

In sum, the challenged provisions of the Actuarial Letter satisfy neither the common-sense test nor the McCarran-Ferguson factors. Consequently, they do not fall within the saving clause and are preempted.

The district court also held that ¶¶ 4, 6, and 7 of the Actuarial Letter do not "relate to" ERISA plans and, accordingly, did not reach the saving clause argument as to those paragraphs. On cross-appeal, Travelers argues that the district court erred to the extent it found that ¶ 4 does not "relate to" ERISA plans.[7] We agree and therefore reverse that part of the district court's decision holding that ¶ 4 is not preempted.

Paragraph 4, like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, is directed at the purchasers of stop-loss coverage which are primarily ERISA plans. It effectively requires the "policyholder" -- which is an ERISA plan -- either to purchase insurance for "run-off claims" or maintain significant reserves of its own. This alone merits a finding that ¶ 4 has a "connection with" employee benefit plans and, therefore, is "relate[d] to" such plans for purposes of ERISA's preemption clause because stop-loss protection will guarantee that benefits are paid to employees even if the carrier suffers catastrophic losses.

Reaching the saving clause argument, we conclude that ¶ 4 does not "regulate insurance" and therefore is not saved from ERISA preemption. In our view, ¶ 4 attempts to regulate, through the self-loss insurer, the benefits offered by and the administrative functioning of self-funded ERISA plans. Paragraph 4 is

[7]The district court's findings as to ¶¶ 6 and 7 are not now challenged by Travelers or the Department of Labor.

similar to the other challenged paragraphs. Like ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, ¶ 4 does not fall within the saving clause and is, therefore, preempted.

We hold, therefore, that the five challenged paragraphs do not regulate insurance within the meaning of the saving clause and, accordingly, are preempted. We affirm the district court's ruling as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

CONCLUSION

To sum up: We find that the district court properly found that plaintiffs' challenges to the 11% and 9% surcharges are not barred by the TIA. Nor is their challenge to the 13% differential barred by laches. Further, the district court properly held that the three surcharges are preempted by ERISA. Finally, we affirm the court's decision as to ¶¶ 1, 2, 3, and 5 of the Actuarial Letter, and reverse as to ¶ 4.

Accordingly, the judgment of the district court is affirmed in part, reversed in part, and the district court is directed to enter judgment consistent with this opinion.

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

THE TRAVELERS INSURANCE COMPANY,

v.

MARIO M. CUOMO, in his Official Capacity as Governor of the State of New York, LORNA MCBARNETTE, in her Official Capacity as Acting Commissioner of Health of the State of New York, and SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York.

Case No. 92 Civ. 3999 (LJF)

Summons in a Civil Action, filed June 2, 1992

TO:

Salvatore R. Curiale
Superintendent of Insurance
Department of Insurance
160 West Broadway
New York, NY 10013

Mario M. Cuomo
Executive Chamber
State Capitol
Albany, NY 12224

Lorna McBarnette
Acting Commissioner
New York State
Dept of Health
Empire State Plaza
Albany, NY 12237

YOU ARE HEREBY SUMMONED and required to file with the Clerk of this Court and serve upon Plaintiff's Attorney

Windels, Marx, Davies & Ives
156 West 56th Street
New York, NY 10019

an answer to the complaint which is herewith served upon you, within 20 days after service of this summons upon you, exclusive of the day of service. If you fail to do so, judgment by default will be taken against you for the relief demanded in the complaint.

JAMES M. PARKISON
Clerk

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Complaint, filed June 2, 1992

[Travelers Ins. Co. v. Cuomo]

Plaintiff The Travelers Insurance Company ("The Travelers"), by its attorneys, Windels, Marx, Davies & Ives, for its complaint in this action, respectfully alleges as follows:

JURISDICTION AND VENUE

1. This is an action for declaratory relief pursuant to 28 U.S.C. §2201 and Rule 57 of the Federal Rules of Civil Procedure, and injunctive relief pursuant to 28 U.S.C. §2202.

2. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1132 (e)(1) in that The Travelers is a person empowered to bring a civil action under Section 502 (a)(3) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1132 (a)(3), and seeks a declaration that certain provisions of New York law are preempted under Section 514 (a) of ERISA, 29 U.S.C. §1144(a). This Court also has jurisdiction of this action under 28 U.S.C. §1332 (a)(1) in that this action is between citizens of different states and the amount in controversy exceeds $50,000.

3. Venue is proper in this judicial district pursuant to 28 U.S.C. §1391 (b) and 29 U.S.C. §1132 (e)(2) in that defendant Curiale resides in this judicial district.

THE PARTIES

4. Plaintiff The Travelers is a corporation organized and existing under the laws of the State of Connecticut with its principal place of business in the State of Connecticut. The Travelers is authorized and licensed to do business in the State of New York.

5. Defendant Mario M. Cuomo is the Governor of the State of New York and is a citizen of the State of New York.

6. Defendant Lorna McBarnette is the Acting Commissioner of Health of the State of New York and is a citizen of the State of New York.

7. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York and is a citizen of the State of New York. Defendant Curiale's official residence is 160 West Broadway, New York, New York 10013.

ALLEGATIONS COMMON TO ALL COUNTS

8. The Travelers and its affiliated and subsidiary companies constitute one of the world's largest multi-line insurance, financial and health services institutions. Among other services, The Travelers provides group accident and health insurance. The Travelers also provides claims administration for employer plans which are fully self-insured or primarily self-insured with excess risk insurance, which is known in the insurance industry as stop-loss coverage. With regard to the handling of claims for many such plans, The Travelers is a fiduciary within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

9. The Travelers has been actively engaged in underwriting group insurance plans for over 75 years, and is a licensed group insurer in all 50 states, the District of Columbia, Puerto Rico, the

Virgin Islands and the Bahamas. The Travelers markets group accident and health insurance through group contracts to employers, employer associations and trusts, and other organizations ranging in size from small local employers to large multinational corporations.

10. The vast majority of employers purchasing either claims administration services or group accident and health insurance from The Travelers are subject to ERISA and its enforcement provisions as administered by the U. S. Department of Labor.

11. Many of the employers purchasing either claims administration services or group accident and health insurance from The Travelers operate in more than one state.

12. In New York State, The Travelers provides either claims administration services or group accident and health insurance to over 430,000 employees and dependents covered by ERISA plans. The Travelers provides the above services or insurance in connection with 4,429 separate ERISA plans.

13. The premiums charged by The Travelers for group insurance coverage reflect assumptions as to claims, investment returns and expenses, and a profit margin. As the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the cost through to the employer by increasing the premium. Similarly, in the case of a self-insured plan, as the cost of the covered treatment increases, the amount of the claims administered by The Travelers and paid by the employer increases.

14. The group accident and health insurance benefits provided by The Travelers under a typical group insurance policy include reimbursement of hospital, surgical and medical expenses, including coverage for inpatient hospital care. With regard to inpatient hospital care, the employee usually executes an

assignment or authorization to pay, and based upon such direction, The Travelers will usually pay directly to the hospital providing the services the amount charged by the hospital for inpatient care, subject to the terms of the policy. Under a typical group insurance policy, The Travelers provides insurance benefits directly to the employee and his dependents.

15. The Travelers also provides stop-loss coverage to self-insured group health plans. The stop-loss policies issued by The Travelers usually provide either individual stop-loss coverage, aggregate stop-loss coverage or both. Under an individual stop-loss provision, The Travelers provides coverage only if the benefits paid by the plan during a policy year to any one individual exceed a specified individual trigger amount, which is set in the policy. Under an aggregate stop-loss provision, The Travelers provides coverage only if the aggregate benefits paid during the policy year exceed an aggregate trigger amount, which is set in the policy. Some of the stop-loss policies issued by The Travelers contain both individual and aggregate stop-loss provisions.

16. Under a stop-loss policy, until the amount of benefits paid by the plan exceeds the applicable trigger amount, The Travelers has no obligation to make payments to either the employer or the employees. If and when the benefits exceed the applicable trigger amount, The Travelers is obligated under the policy to reimburse the employer for the amount of payments above the trigger amount. However, unlike a group insurance policy, The Travelers has no obligation to the employees or their dependents. In many instances, the stop-loss programs administered by The Travelers operate for years without paying benefits over the applicable trigger amount.

17. B.H. Aircraft Company, Inc. ("B.H. Aircraft") is a New York corporation with its principal place of business in Farmingdale, New York. B.H. Aircraft is in the business of

manufacturing aircraft parts, and conducts its operations in New York.

18. B.H. Aircraft provides group accident and health insurance to 122 employees under a plan which is subject to ERISA (the "B.H. Plan"). The Travelers has issued a policy to B.H. Aircraft which provides accident and health insurance to B.H. Aircraft's employees and their dependents (the "B.H. Policy"). The B.H. Plan and the B.H. Policy provide coverage to 121 employees of B.H. Aircraft in New York and one employee in Connecticut. The Travelers pays claims made by employees of B.H. Aircraft and their dependents. With regard to the adjudication of such claims, The Travelers is a fiduciary of the B.H. Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

19. The B.H. Policy includes coverage for the amount charged to an employee for inpatient hospital care. The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital coverage. The B.H. Policy is typical of the group health insurance policies which The Travelers issues to employers in the State of New York.

20. Sheridan Catheter Corporation ("Sheridan Catheter") is a New York corporation with its principal place of business in Argyle, New York. Sheridan Catheter is in the business of producing medical equipment and supplies, and conducts its operations in New York, but with sales staff in the following additional states: California, Georgia, Illinois, Maryland, Missouri, Ohio, Pennsylvania, Tennessee, Texas and Washington.

21. Sheridan Catheter provides group accident and health benefits to 242 employees under a plan which is subject to the terms of ERISA (the "Sheridan Catheter Plan"). The Sheridan Catheter Plan is self-insured. The Sheridan Catheter Plan provides coverage to 232 employees of Sheridan Catheter in New

York, and 10 employees in the other states listed in paragraph 20. The Sheridan Catheter Plan provides coverage to Sheridan Catheter's employees for inpatient hospital care. Claims are administered pursuant to an administrative services only agreement with The Travelers (the "Sheridan Catheter Contract"). With regard to the administration of such claims, The Travelers is a fiduciary of the Sheridan Catheter Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

22. In addition, Sheridan Catheter has purchased a stop-loss policy from The Travelers which provides both individual and aggregate stop-loss coverage (the "Sheridan Catheter Policy"). Under the aggregate stop-loss provision of the Sheridan Catheter Policy, The Travelers provides coverage only if the aggregate benefits paid by Sheridan Catheter during the applicable contract period exceed 125% of annual anticipated health care claims. Under the individual stop-loss provision of the Sheridan Catheter Policy, The Travelers provides coverage only if benefits paid by Sheridan Catheter during the applicable policy period for any one employee or dependent exceed $90,000. Until the benefits paid by Sheridan Catheter exceed the individual or aggregate trigger amount, The Travelers administers claims on Sheridan Catheter's behalf using funds provided by Sheridan Catheter. If the benefits paid by Sheridan Catheter exceed the individual or aggregate trigger amount, under the terms of the Sheridan Catheter Policy, The Travelers reimburses Sheridan Catheter for the amount of payments above the applicable trigger amount. Unlike a group insurance policy, The Travelers has no obligation to pay benefits to Sheridan Catheter employees under the Sheridan Catheter Policy.

23. The Sheridan Catheter Policy is typical of the stop-loss policies issued by The Travelers in order to provide excess risk insurance to self-insured plans. An employer's purchase of excess risk insurance to protect against catastrophic loss does not alter the fact that the plan is essentially self-insured.

COUNT I

(CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE SUPPLEMENTAL 11% SURCHARGE)

24. The Travelers repeats and realleges paragraphs 1 through 23 of this complaint as if fully set forth herein.

25. Under Section 2807-c of the New York Public Health Law, the rate of payment to general hospitals for inpatient hospital care in New York is regulated. Except in cases such as that of an uninsured person, the rates for inpatient hospital care are generally set on the basis of categories relating to the diagnosis of illness, known as Diagnosis Related Groups or DRG's. Under this system, the amount charged for inpatient hospital care is set on the basis of the DRG into which the patient falls, rather than the actual cost of the treatment. In addition, as described below, the DRG amount is multiplied by a "payor factor" which creates a differential among the amounts charged to various payors such as a self-insured plan, health maintenance organization, The Travelers or a Blue Cross company.

26. Under Section 2807-c(1)(a), the rate of general hospital inpatient reimbursement for patients eligible for payments made by state governmental agencies or pursuant to a Blue Cross plan is the applicable DRG rate.

27. Under Section 2807-c(1)(b), the rate of general hospital inpatient reimbursement for patients "enrolled in a self-insured fund which provides for reimbursement directly to general hospitals on an expense incurred basis" is 113% of the applicable DRG rate.

28. Prior to April 1, 1992, under Section 2807-c(1)(b), the rate of general hospital inpatient reimbursement for a person "insured under a commercial insurer licensed to do business in [New York]

and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, and the insurer makes payments directly to the general hospital" was 113% of the applicable DRG rate.

29. Prior to April 1, 1992, the revenue raised under Section 2807-c(1)(b) was available to the hospital providing the service to offset the cost of providing health care.

30. On April 2, 1992, the New York Legislature passed the Omnibus Tax Revenue Act of 1992 ("the Act"). As relevant to the allegations herein, the Act became effective immediately. Section 348 of the Act imposes an additional surcharge of 11% on the DRG rates paid by commercial insurance companies under section 2807-c(1)(b) for inpatient hospital care. This additional 11% is not available to hospitals to cover the cost of providing medical care. Instead, Section 349 of the Act requires that the 11% surcharge be paid by or on behalf of the collecting hospitals into a statewide pool maintained by the Commissioner of Health, who, in turn, pays these monies into the New York State General Fund.

31. Specifically, Section 348 of the Act provides, in pertinent part, as follows:

> Paragraph (i) of subdivision 11 of section 2807-c of the public health law is REPEALED and a new paragraph (i) is added to read as follows:
>
> (i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an

expense incurred basis, the payment rate shall be increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent.

32. Section 349 of the Act provides, in pertinent part, as follows:

> Section 2807-c of the public health law is amended by adding a new subdivision 14-e to read as follows:
>
> 14-e. Supplementary payment rate conversion factor statewide pool. (a) Funds will be accumulated in a statewide pool created by the commissioner [of Health] through the submissions by or on behalf of general hospitals of the component of rates of payment reflecting the supplementary payment rate conversion factor provided in accordance with paragraph (i) of subdivision eleven of this section.
>
> (b) Funds accumulated in the supplementary payment rate conversion factor statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

33. Because Section 348 of the Act is void and unenforceable for the reasons described below, The Travelers is not paying the supplemental 11% surcharge for inpatient hospital care rendered to a person insured by The Travelers in connection with an ERISA plan. Instead, in each such case, The Travelers is segregating the amount due for the supplemental 11% surcharge.

The Travelers will pay all amounts due if this Court finds that Section 348 of the Act is enforceable. The Travelers is continuing to pay the 13% surcharge.

34. ERISA was enacted by Congress for the purpose, among others, of regulating employee welfare benefit plans through a uniform, nationwide, regulatory scheme governing such plans.

35. Section 514(a) of ERISA, 29 U.S.C. §1144(a), provides, in pertinent part, that ERISA:

> shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title [29 U.S.C. §1003(a)] . . . .

36. Section 348 of the Act imposes a supplemental 11% surcharge on plans such as the B.H. Plan which provide coverage for inpatient hospital care to employees through an insurance policy issued by a commercial insurer such as The Travelers.

37. Under Section 349 of the Act, the 11% supplemental surcharge ultimately is paid into the New York State General Fund. The hospital providing the service does not retain any of the revenue raised as a result of the supplemental 11% surcharge.

38. The supplemental 11% surcharge has a substantial effect on the operation of an ERISA plan such as the B.H. Plan. When coupled with the 13% surcharge provided for in Section 2807-c(1)(b), the supplemental 11% surcharge imposes a substantial penalty on any ERISA plan which chooses to obtain coverage for inpatient hospital care from a commercial insurer such as The Travelers rather than from a Blue Cross company.

39. The supplemental 11% surcharge also places The Travelers at a significant disadvantage with regard to the marketing and sale of group health insurance.

40. Section 348 of the Act relates to an employee benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

41. Section 348 of the Act is preempted by ERISA and should be declared null and void and unenforceable by defendants.

42. Section 348 of the Act is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT II

(CLAIM FOR DECLARATION THAT SECTION 348 OF THE ACT DOES NOT APPLY TO PAYMENTS MADE BY SELF-INSURED PLANS)

43. The Travelers repeats and realleges paragraphs 1 through 42 of this complaint as if fully set forth herein.

44. Defendant McBarnette takes the position that Section 348 of the Act applies to self-insured plans with stop-loss coverage purchased by employers from a commercial insurer such as The Travelers.

45. This interpretation is contrary to the plain language of Section 348 of the Act which provides that the supplemental 11% surcharge only applies in the case of a patient "insured" by a "commercial insurer . . . whose policy provides inpatient hospital coverage on an expense incurred basis." Unlike the existing 13% surcharge under Section 2807-c(1)(b), which clearly applies in the case of patients "enrolled in a self-insured

fund," Section 348 of the Act makes no reference to persons covered by a self-insured plan.

46. The Sheridan Catheter Plan is self-insured. Until the benefits paid in any one-year period by Sheridan Catheter exceed the individual or aggregate trigger amount, Sheridan Catheter pays all claims. Even after the trigger amount has been exceeded, employees and dependents under the Sheridan Catheter plan are not "insured" by a "commercial insurer . . . whose policy provides inpatient hospital coverage on an expense incurred basis." Under the terms of the Sheridan Catheter Policy, The Travelers does not insure the employee and his dependents or pay for inpatient hospital care. Instead, The Travelers reimburses Sheridan Catheter for the amount of payments in excess of the individual or aggregate trigger amount. Such reimbursement is not insuring a patient for inpatient hospital coverage under Section 2807-c(1)(b).

47. The stop-loss policies issued by The Travelers in connection with other self-insured plans are similar to the Sheridan Catheter Policy. Each policy providing aggregate stop-loss coverage provides reimbursement to the employer only after the employer has paid claims of a substantial amount, equal to at least 100% of the employer's annual anticipated health care claims. This means that unless the self-insured employer's total actual annual health care claims exceed the total anticipated claims, there is no insurance coverage provided under the aggregate stop-loss provision of the policy. Even when the aggregate trigger amount has been exceeded, The Travelers does not provide insurance benefits to the employee or his dependents. Instead, The Travelers reimburses the employer for the gross amount of claims in excess of the trigger amount. The same is true with regard to the individual stop-loss provisions of the stop-loss policies issued by The Travelers.

48. Defendants' interpretation of Section 348 imposes a substantial penalty on self-insured plans with stop-loss coverage such as the Sheridan Catheter Plan, and drives up the costs of providing benefits to persons covered under such plans.

49. Defendants' interpretation of Section 348 also has a substantial impact on the business of The Travelers. Imposition of the supplemental surcharge to such claims increases the overall cost to the plan of the claims administered by The Travelers.

50. Accordingly, plaintiff The Travelers is entitled to a declaration that the supplemental 11% surcharge does not apply in the case of any patient covered by the Sheridan Catheter Plan or any other self-insured plan with stop-loss coverage provided by The Travelers.

COUNT III

(ALTERNATIVE CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE SUPPLEMENTAL 11% SURCHARGE)

51. The Travelers repeats and realleges paragraphs 1 through 50 of this complaint as if fully set forth herein.

52. If this Court concludes that Section 348 of the Act applies to self-insured ERISA plans with stop-loss coverage, the supplemental 11% surcharge will have a substantial effect on the operation of self-insured ERISA plans such as the Sheridan Catheter Plan.

53. When coupled with the 13% surcharge provided for in Section 2807-c(1)(b), the supplemental 11% surcharge imposes a substantial penalty on any ERISA plan which chooses to provide coverage to participants on a self-insured basis with stop-loss coverage rather than obtaining coverage from a Blue Cross company.

54. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act relates to an employee welfare benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

55. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act is preempted by ERISA and should be declared null and void and unenforceable by defendants.

56. If interpreted to apply to a self-insured ERISA plan with stop-loss coverage, Section 348 of the Act is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT IV

(CLAIM FOR DECLARATION THAT ERISA PREEMPTS THE 13% SURCHARGE)

57. The Travelers repeats and realleges paragraphs 1 through 56 of this complaint as if fully set forth herein.

58. Section 2807-c(1)(b) imposes a 13% surcharge for inpatient hospital care rendered to persons covered by either a self-insured ERISA plan such as the Sheridan Catheter Plan or an ERISA plan with insurance provided by a commercial insurer such as the B.H. Plan.

59. Section 2807-c(1)(b) imposes a 13% surcharge on those employers who decide to provide coverage to their employees under a self-insured plan or pursuant to a policy of insurance obtained from a commercial insurer, rather than obtaining coverage from a Blue Cross company. This additional 13% surcharge has a substantial impact on the ability of an employer to provide coverage for inpatient hospital care to its employees.

60. The 13% surcharge also has a substantial impact on the business of The Travelers. In the case of an insured plan such as the B.H. Plan, the 13% surcharge causes The Travelers to increase the premium it charges for a group policy. In the case of a self-insured plan such as the Sheridan Catheter Plan, the 13% surcharge increases the overall cost to the plan of the claims administered by The Travelers. In each case, the 13% surcharge interferes with The Travelers ability to sell its services on a competitive basis.

61. Section 2807-c(1)(b) relates to an employee welfare benefit plan, within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

62. Section 2807-c(1)(b) is preempted by ERISA and should be declared null and void and unenforceable by defendants.

63. Section 2807-c(1)(b) is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

COUNT V

(CLAIM FOR DECLARATION THAT THE ACTUARIAL LETTER IS UNENFORCEABLE)

64. The Travelers repeats and realleges paragraphs 1 through 23, 34 and 35 of this complaint as if fully set forth herein.

65. Actuarial Information Letter Number Five (the "Actuarial Letter") issued by defendant Curiale sets forth substantive and procedural requirements which must be satisfied before the Department of Insurance will approve the form of a stop-loss policy such as the Sheridan Catheter Policy.

66. Sections 3216 and 3221 of The New York Insurance Law require that insurers issuing accident and health insurance

policies include certain statutorily mandated benefits. Section 3221 of the New York Insurance Law also mandates conversion privileges for group or blanket accident and health insurance policies. These laws apply to insurers, and not to self-insured plans.

67. The Actuarial Letter requires, as a condition for the approval of a stop-loss policy, that the policy or an undertaking signed by the insurer provide (1) that the insurer undertake to ensure that the employee benefit plan covered by the policy provide statutorily mandated benefits, (2) that the insurer undertake to ensure that statutorily mandated conversion policies be provided, (3) that notice be given to employees when the insurer becomes liable for run-off claims, and (4) that the insurer take primary responsibility for the payment of employee benefit plan claims incurred but unpaid at the policy termination date (unless certain conditions are met). Thus, the Actuarial Letter requires that a self-insured ERISA plan provide its employees with certain mandated benefits and guarantees if the plan obtains any form of stop-loss coverage.

68. The Actuarial Letter establishes substantive and procedural requirements which clearly are intended to govern the terms of self-insured group health plans. Accordingly, in order to be enforceable, the provisions of the Actuarial Letter would have to be promulgated as a rule in accordance with the provisions of the New York State Administrative Procedure Act ("NYSAPA"). Sections 202 and 202-a of the NYSAPA require public notice of a proposed regulation, "an opportunity to be heard" and the filing of a regulatory impact statement. In addition, under Section 203 of the NYSAPA and Section 102 of the New York Executive Law, prior to becoming effective, a proposed regulation must be filed by the Insurance Department with the Secretary of State who shall compile the regulation and publish it in the "official compilation of codes, rules and regulations of the state of New York."

69. Defendant Curiale has not promulgated the provisions of the Actuarial Letter as a rule in accordance with the above provisions of the NYSAPA and the Executive Law.

70. Accordingly, the Actuarial Letter is not enforceable with regard to any stop-loss policy issued by The Travelers.

COUNT VI

(ALTERNATIVE CLAIM THAT ERISA PREEMPTS THE ACTUARIAL LETTER)

71. The Travelers repeats and realleges paragraphs 1 through 23, 34, 35, and 65 through 70 of this complaint as if fully set forth herein.

72. If this Court concludes that the Actuarial Letter is enforceable against The Travelers under New York law, then this Court should rule that ERISA preempts the application of the Actuarial Letter to any stop-loss policy issued by The Travelers in connection with a self-insured ERISA plan.

73. The Actuarial Letter requires that a self-insured ERISA plan provide the benefits and guarantees set forth in the Actuarial Letter in order to obtain stop-loss coverage. Accordingly, if enforceable, the Actuarial Letter relates to an employee benefit plan within the meaning of Section 514(a) of ERISA, 29 U.S.C. §1144(a).

74. If enforceable, the Actuarial Letter is preempted by ERISA and should be declared null and void and unenforceable by defendants.

75. If enforceable, the Actuarial Letter is not saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. §1144(b)(2)(A).

WHEREFORE, plaintiff The Travelers demands judgment:

(a) declaring and determining that ERISA preempts the application of the supplemental 11% surcharge of Section 348 of the Act in the case of any person participating in an ERISA plan, and enjoining defendants from enforcing the 11% supplemental surcharge in such cases;

(b) declaring and determining that the 11% supplemental surcharge of Section 348 of the Act does not apply to a person covered under a self-insured plan with stop-loss coverage, and enjoining defendants from enforcing the 11% supplemental surcharge in such cases;

(c) declaring and determining that ERISA preempts the application of the 13% surcharge of New York Public Health Law Section 2807-c(1)(b) in the case of any person participating in an ERISA plan, and enjoining defendants from enforcing the 13% surcharge in such cases;

(d) declaring and determining that the Actuarial Letter is not enforceable, and enjoining defendants from enforcing it;

(e) declaring and determining that ERISA preempts the enforcement of the Actuarial Letter with regard to any stop-loss policy issued in connection with an ERISA plan, and enjoining the defendants from enforcing the Actuarial Letter in such cases; and

(f) awarding plaintiff The Travelers the costs incurred in prosecuting this action, including reasonable attorneys' fees.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

THE HEALTH INSURANCE ASSOCIATION OF AMERICA, THE AMERICAN COUNCIL OF LIFE INSURANCE, THE LIFE INSURANCE COUNCIL OF NEW YORK, INC., AETNA LIFE INSURANCE COMPANY, AETNA HEALTH PLANS OF NEW YORK, INC., MUTUAL OF OMAHA INSURANCE COMPANY, THE UNION LABOR LIFE INSURANCE COMPANY, AND PROFESSIONAL INSURANCE AGENTS OF NEW YORK, INC. TRUST,

Plaintiffs,

-against-

MARK CHASSIN, M.D., in his Official Capacity as Commissioner of Health of the State of New York, MARY JO BANE in her Official Capacity as Commissioner of Social Services of the State of New York, SALVATORE R. CURIALE, in his Official Capacity as Superintendent of Insurance of the State of New York, and ROBERT ABRAMS, in his Official Capacity as Attorney General of the State of New York,

Defendants.

Case No. 92 Civ. 5419 (LJF)

Amended Complaint, filed August 10, 1992

Plaintiffs, by their undersigned attorneys, for their complaint, allege:

NATURE OF THE ACTION

1. This action seeks to invalidate certain laws of the State of New York on the ground that they are preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which (with exceptions not applicable here) expressly supersedes all state laws and regulations "insofar as they . . . relate to any employee benefit plan" covered by ERISA.

2. Under the recently enacted Omnibus Revenue Act of 1992 ("the Act"), New York requires hospitals to impose an 11% surcharge on bills to patients covered by commercial health insurance and to pay over this 11% surcharge to the State of New York for inclusion in its general revenues. The 11% surcharge is imposed *only* to the extent that patients are covered by commercial health insurance. The surcharge, thus, does not apply at all to bills for patients who are covered by Blue Cross, who belong to health maintenance organizations ("HMOs"), who are self-insured, or who have no insurance.

3. Moreover, this 11% surcharge is added to a previously enacted 13% surcharge imposed by section 2807-c(1)(b) of New York's Public Health Law ("the Statute"), on hospital bills to virtually all patients with any form of health coverage other than a Blue Cross plan, an HMO, or a government plan such as Medicare. The funds from the 13% surcharge are retained by the hospital for its own use.

4. Finally, the Act, in certain circumstances, imposes a surcharge of up to 9% that applies only to bills for inpatient hospital care to persons who belong to HMOs.

5. In New York, the vast majority of persons covered by commercial health insurance and self-insured plans, and a substantial number of the persons subscribing to HMOs, receive

that coverage pursuant to employee benefit plans subject to ERISA. The primary effect of these surcharges, therefore, is to increase the cost of benefits paid out by ERISA employee benefit plans that use any of these methods to provide health coverage for their participants and beneficiaries. Moreover, these surcharges create differentials between the cost of benefits to ERISA employee benefit plans, depending on the method used by the plan to provide health benefits. For example, the bills for hospital care under an ERISA employee benefit plan covered by commercial health insurance are 24% more than if the plan were covered by Blue Cross and 11% more than if the plan were self-insured.

6. The inevitable effect of these surcharges is to increase the cost of commercially-insured and self-insured employee benefit plans, reduce the coverage provided by such employee benefit plans, or force employers and plan administrators to choose other means for funding employee benefit plans. In certain circumstances, the surcharges will have similar effects on ERISA employee benefit plans that utilize HMOs. These surcharges therefore will force employers or plan administrators to tailor their ERISA employee benefit plans to the peculiarities of New York law.

7. In sum, the New York laws imposing these surcharges have direct, profound and detrimental effects upon ERISA employee benefit plans. They are, therefore, laws that "relate to" employee benefit plans, and are superseded by ERISA and rendered invalid under the Supremacy Clause of the United States Constitution.

JURISDICTION AND VENUE

8. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 in that the dispute arises under the Supremacy Clause of the Constitution of the United States, and the suit is also brought

pursuant to 29 U.S.C. § 1132(a)(3). Plaintiffs seek declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202.

9. Venue is proper pursuant to 28 U.S.C. § 1391(b) and 29 U.S.C. 1132(e)(2) in that defendants Salvatore R. Curiale and Robert Abrams reside in the Southern District of New York, a substantial part of the events giving rise to the claim have occurred and continue to occur in the Southern District of New York, and many of the employee benefit plans that are the subject of this lawsuit are administered there.

THE PARTIES

10. Plaintiff Health Insurance Association of America ("HIAA") is a trade association organized to promote and protect the interests of its members, which are commercial writers of health insurance throughout the United States. It represents the interests of approximately 300 member companies that provide health coverage to over 90 million people in the United States. On information and belief, HIAA's members also issue the great majority of the commercial group health insurance policies in the State of New York. The vast majority of these policies and the group health insurance policies issued by members of the other trade association plaintiffs in New York are purchased pursuant to employee benefit plans as defined by ERISA ("employee benefit plans"). Many of the employee benefit plans that purchase commercial health insurance from members of HIAA (and from the other plaintiffs) to cover employees in New York also cover employees in other states. HIAA is itself the fiduciary for an employee benefit plan that provides commercially-insured health and hospital coverage to former HIAA employees residing in New York.

11. Many of HIAA's members also serve as claims administrators and claims fiduciaries for self-insured ERISA

plans that provide inpatient hospital coverage in New York (hereafter referred to as the "self-insured plans").

12. Some of HIAA's members also own, in whole or in part, HMOs organized pursuant to Article 44 of New York's Public Health Law. Such HMOs provide full health coverage, including coverage of inpatient hospital care, to subscribers, many of whom are enrolled pursuant to employee benefit plans.

13. The amount of dues HIAA assesses on its members is primarily determined by the total insurance premiums and the amount of claims its members process in administering self-insured plans. HIAA brings this suit on behalf of its members as well as on its own behalf.

14. Plaintiff American Council of Life Insurance ("ACLI") is a trade association representing 611 companies, of which 125 are licensed to do business in New York. ACLI's members write approximately 95% of the life insurance and about 80% of the health insurance policies currently purchased in the United States and in the State of New York. On information and belief, ACLI's members, many of which also belong to HIAA, issue the vast majority of the commercially-insured group health insurance policies in the State of New York. The vast majority of those policies are issued pursuant to employee benefit plans as defined by ERISA. Some of ACLI's members serve as claims administrators and claims fiduciaries for certain self-insured plans in the State. ACLI itself is the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to ACLI's employees and to certain HIAA employees in New York. Some of ACLI's members also own, in whole or in part, HMOs which enroll a large number of subscribers pursuant to employee benefit plans. The amount of dues ACLI assesses on its members is primarily determined by the total premiums its members receive. ACLI brings this suit on behalf of its members as well as on its own behalf.

15. Plaintiff Life Insurance Council of New York, Inc. ("LICONY") is a trade association with 64 members organized to promote and protect the interests of its members—commercial writers of life insurance in the State of New York—some of which write health insurance policies. On information and belief, LICONY's members—most of which also belong to HIAA or ACLI—write a significant percentage of the commercial health insurance policies in New York State, most of which are purchased pursuant to employee benefit plans. In addition, LICONY's members serve as claims administrators and claims fiduciaries for self-insured plans in New York. Two of LICONY's members own, in whole or in part, HMOs which enroll a large number of subscribers pursuant to employee benefit plans. LICONY is itself the fiduciary for an employee benefit plan that provides commercially-insured health and hospital coverage to LICONY's employees in New York. The amount of dues LICONY assesses on its members is determined by the total premiums its members receive and its members' assets. LICONY brings this suit on behalf of its members as well as on its own behalf.

16. Plaintiff Aetna Life Insurance Company ("Aetna Life") is a commercial insurance company authorized to do business in New York, and in all of the fifty states. Aetna Life issues commercial health and hospital insurance coverage to employee benefit plans with participants in New York and is the claims fiduciary for such plans. Aetna Life also administers self-insured plans in New York and serves as claims fiduciary for many such plans.

17. Plaintiff Aetna Health Plans of New York, Inc. ("Aetna Health Plans") is an HMO licensed in the State of New York that provides health coverage, including hospital coverage, to its enrollees. Enrollment in Aetna Health Plans is offered as an option to participants in the employee benefit plans covering employees of Aetna Life and Aetna Health Plans in New York

and to participants in other employee benefit plans in the State. Aetna Health Plans serves as fiduciary for claims filed by its enrollees.

18. Plaintiff Mutual of Omaha Insurance Company ("Mutual of Omaha") is a mutual insurance company authorized to do business in the State of New York and in all of the fifty states. Mutual of Omaha issues commercial health and hospital insurance coverage for employee benefit plans and is a claims fiduciary for those plans. Mutual of Omaha is itself the fiduciary for a self-insured employee benefit plan that provides health and hospital coverage to employees of Mutual of Omaha and its subsidiaries and affiliates residing in New York.

19. Plaintiff The Union Labor Life Insurance Company ("Union Labor") is a commercial insurance company licensed to do business in New York and in all fifty states. Union Labor issues commercial health and hospital insurance coverage to employee benefit plans in New York State. Union Labor is also an administrator for certain self-insured plans in New York. Union Labor is itself the fiduciary for a commercially-insured employee benefit plan that provides health and hospital coverage to employees of Union Labor and its affiliates residing in New York.

20. Plaintiff Professional Insurance Agents of New York, Inc. Trust ("PIA Trust") is the fiduciary for a commercially-insured employee benefit plan that provides benefits, including health and hospital coverage, to members of the Professional Insurance Agents of New York State, Inc. and to similar groups in two other states.

21. Defendant Mark Chassin, M.D. is the Commissioner of Health of the State of New York. The Department of Health of the State of New York (the "Department of Health") is charged with administering the 13% surcharge imposed by the Statute and the

11% surcharge imposed by the Act. Defendant Chassin maintains an office at Nelson Rockefeller Empire State Plaza, Corning Tower Building, Albany, New York 12237.

22. Defendant Mary Jo Bane is the Commissioner of Social Services of the State of New York, and is charged with administering the surcharges on HMOs imposed by the Act. Defendant Bane maintains an office at 40 North Pearl Street, Albany, New York 12243.

23. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York. Pursuant to Section 335 of the Insurance Law of the State of New York, defendant Curiale is empowered to prescribe and enforce rules and regulations governing insurance procedures that relate to the implementation of the hospital reimbursement provisions of the Public Health Law, including reimbursements giving rise to surcharges at issue in this litigation. Defendant Curiale maintains an office at 160 West Broadway, New York, New York 10013 which is his official residence.

24. Defendant Robert Abrams is the Attorney General of the State of New York, and is charged with enforcing compliance with the State's laws and regulations, including those at issue in this litigation, under New York Executive Law § 63(1) and (12). The Attorney General maintains an office at 120 Broadway, New York, New York 10271 which is his official residence.

NEW YORK'S SURCHARGES ON HOSPITAL BILLS FOR PATIENTS COVERED BY COMMERCIAL INSURANCE AND SELF-INSURED PLANS

25. Under New York's Public Health Law, the State, with certain exceptions, requires hospitals to charge standardized payment rates for inpatient care. Public Health Law § 2807-c(1). Under this system, medical procedures are divided into categories

based on the patient's diagnosis, known as Diagnosis Related Groups ("DRG"s). Public Health Law § 2807-c(1)(A). Hospitals are required by law to charge, and payors are required to pay, the DRG rate applicable to an insured patient's diagnosis, as adjusted by a formula reflecting costs specific to each individual hospital. The actual amount charged for inpatient hospital care varies, however, depending on whether the individual patient is covered by a health plan and the type of such plan.

26. Under Section 2807-c(1)(b) of the Public Health Law, the DRG rate is increased by a 13% surcharge ("the 13% Surcharge") imposed on payments for inpatient services to virtually all patients covered by any form of health plan (including commercially insured and self-insured employee benefit plans), except for patients covered by Blue Cross, an HMO, or government plans like Medicare. The funds generated by this 13% surcharge are retained by the hospital.

27. Section 348 of the Omnibus Revenue Act of 1992, adopted on April 2, 1992, amends New York's Public Health Law to impose an additional eleven percent (11%) surcharge (the "11% Surcharge") on DRG payment rates charged by hospitals *only* to patients insured by commercial insurers. Section 348 of the Act provides in relevant part:

> Paragraph (i) of subdivision 11 of section 2807-c of the public health law is REPEALED and a new paragraph (i) is added to read as follows:
>
> (i) For patients discharged during the period April first, nineteen hundred ninety-two through March thirty-first, nineteen hundred ninety-three insured under a commercial insurer licensed to do business in this state and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on an expense incurred basis, the payment rate shall be

increased in addition to the payment rate conversion factor of thirteen percent by a supplementary payment rate conversion factor of eleven percent for a total conversion factor of twenty-four percent. . . .

28. The Act requires hospitals to submit the funds raised by the 11% Surcharge to a pool established by the Commissioner of Health, who, in turn, must deposit those funds into the State's general fund. Thus, Section 349 provides:

> Section 2807-c of the public health law is amended by adding a new subdivision 14-e to read as follows:
>
> 14-e. Supplementary payment rate conversion factor statewide pool. (a) Funds will be accumulated in a statewide pool created by the commissioner through the submissions by or on behalf of general hospitals of the component of rates of payment reflecting the supplementary payment rate conversion factor provided in accordance with paragraph (i) of subdivision eleven of this section.
>
> (b) Funds accumulated in the supplementary payment rate conversion factor statewide pool, including income from invested funds, shall be deposited by the commissioner and credited to the general fund.

29. Inasmuch as commercial health insurance plans usually do not cover 100% of the DRG rate (because of coinsurance, deductibles or other policy limitations), the Department of Health has interpreted the 11% Surcharge to apply only to that portion of the hospital charges reimbursable under commercial health insurance. Hence, in the case of employee benefit plans covered by commercial health insurance, the 11% Surcharge is imposed only on the hospital charges covered by the employee benefit plan.

NEW YORK'S SURCHARGES ON HOSPITAL BILLS FOR PATIENTS ENROLLED IN HMOs

30. Section 346 of the Act, effective as of July 1, 1992, sets forth several methods for determining the standardized rate applicable to inpatient care rendered to HMO subscribers, ranging from the DRG rate to standardized rates negotiated by the particular HMO.

31. Section 346 of the Act amends New York's Public Health Law to impose a surcharge of up to nine percent (9%) on the applicable rates hospitals charge for inpatient care to HMO subscribers (the "HMO Surcharge"). Section 346 of the Act provides that the HMO Surcharge may be reduced by up to seven percent (7%) for HMOs that provide certain services or achieve certain goals. The Act also provides for elimination of all or part of the HMO Surcharge in certain circumstances.

32. Pursuant to Section 346, beginning on July 1, 1992, each HMO must pay the amount it owes each month for the HMO Surcharge directly into a statewide pool to be established by the Commissioner of Social Services of the State of New York, for deposit into the State's general fund.

THE IMPACT OF THE NEW YORK SURCHARGES

Employee Benefit Plans Covered by Commercial Health Insurance

33. Inasmuch as the vast majority of commercial health insurance contracts in New York State are written to cover employee benefit plans, the primary effect of the 11% and 13% Surcharges is to raise the cost of benefit plans covered by commercial health insurance.

34. The surcharges force employee benefit plans covered by commercial health insurance to pay out benefits that are 24% higher for the same services than would be paid if such plans were covered by Blue Cross, 11% higher than if such plans were self-insured, and at least 15% to 24% higher than if such plans provided health coverage through an HMO.

35. Inasmuch as the premiums for commercial health insurance reflect the cost of claims for hospital services, the 11% and 13% Surcharges increase the premiums charged by commercial health insurers to employee benefit plans covered by commercial insurance.

36. As a result of the 11% and 13% Surcharges, administrators and fiduciaries of employee benefit plans covered by commercial health insurance, including plaintiff trade associations, Union Labor and PIA Trust, are forced to accept higher premiums or reduced benefit coverage, or choose some other method for providing coverage under the plan that is not subject to the 11% or 13% Surcharge. The 11% and 13% Surcharges thus force administrators or fiduciaries of employee benefit plans covered by commercial health insurance to tailor their ERISA plans to the peculiarities of New York law.

37. As a result, commercial insurers, including the members of the plaintiff trade associations, are likely to lose business and the plaintiff trade associations are threatened with a loss of dues.

Self-Insured Employee Benefit Plans

38. Inasmuch as the vast majority of self-insured plans in New York are employee benefit plans, the 13% Surcharge directly raises the cost of employee benefit plans that are self-insured.

39. The 13% Surcharge forces employee benefit plans that are self-insured, including the plan operated by plaintiff Mutual of

Omaha, to pay out benefits that are 13% higher for the same services than would be paid out if the plans were covered by Blue Cross and at least 4% to 13% higher than if the plans subscribed to an HMO.

40. As a result of the 13% Surcharge, self-insured employee benefit plans, including Mutual of Omaha, are forced to accept higher costs, or reduce benefit coverage, or choose some other method of providing coverage under the plan that is not subject to the 13% Surcharge. The 13% Surcharge thus forces administrators or fiduciaries of employee benefit plans that are self-insured to tailor their ERISA plans to the peculiarities of New York law.

41. As a result, commercial insurers are threatened with loss of the income they receive from administering self-insured plans. The trade association plaintiffs are threatened with a further loss of dues.

Employee Benefit Plans Utilizing HMOs

42. In certain circumstances, the HMO Surcharge raises the cost of providing health coverage through an HMO by as much as 9%. The HMO Surcharge thus directly increases the cost of providing hospital care to certain HMO subscribers enrolled pursuant to employee benefit plans.

43. As a result of the HMO Surcharge, administrators of employee benefit plans providing health care in whole or in part through an HMO (including plans covering employees of plaintiffs Aetna Life and Aetna Health Plans) will, in certain circumstances, be forced to pay more for HMO coverage, accept reduced HMO benefits, or choose Blue Cross—which is exempt from all of the surcharges—as a method for providing coverage under such plans. The HMO Surcharge therefore forces administrators or fiduciaries of employee benefit plans providing

health and hospital coverage through an HMO, including plans covering employees of Aetna Life and Aetna Health Plans, to tailor their ERISA plans to the pecularities of New York law.

44. As a result, members of plaintiff trade associations that own all or part of an HMO, including plaintiff Aetna Health Plans, will lose HMO business.

COUNT ONE
(ERISA PREEMPTS THE 11% SURCHARGE)

45. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 44 above.

46. Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ." Section 514(c)(1) of ERISA, 29 U.S.C. § 1144(c)(1), provides that "[t]he term 'State Law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State."

47. Section 348 of the Act, which imposes the 11% Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

48. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 348 of the Act, insofar as it imposes the 11% Surcharge on the payment rate for hospital care to patients covered by an employee benefit plan, is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

49. Plaintiffs are threatened with imminent irreparable injury.

50. Plaintiffs have no adequate remedy at law.

COUNT TWO
(ERISA PREEMPTS THE 13% SURCHARGE)

51. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 50 above.

52. Section 2807-c(1)(b) of the Statute, which imposes the 13% Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

53. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 2807-c(1)(b) of the Statute, insofar as it imposes the 13% Surcharge on the payment rate for hospital care to patients covered by an employee benefit plan, is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

54. Plaintiffs are threatened with imminent irreparable harm.

55. Plaintiffs have no adequate remedy at law.

COUNT THREE
(ERISA PREEMPTS THE HMO SURCHARGE)

56. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 55 above.

57. Section 346 of the Act, which imposes the HMO Surcharge, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

58. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, Section 346 of the Act, insofar as it imposes surcharges on payment rates for hospital care to patients covered by an employee benefit plan, is

preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

59. Plaintiffs are threatened with imminent irreparable harm.

60. Plaintiffs have no adequate remedy at law.

COUNT FOUR
(PREEMPTION UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS ACT)

61. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 60 above.

62. Plaintiff Mutual of Omaha also issues commercial insurance policies that provide health and hospital coverage to federal employees pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. 8901, *et seq.*

63. Under FEHBA, an employee health benefits fund is established in the United States Treasury, administered by the Office of Personnel Management (the "Fund"). This Fund is used to pay approved health benefits, administration expenses and insurance premiums.

64. Thus, under FEHBA, premiums paid to plaintiff Mutual of Omaha are used to pay health and hospital charges incurred by federal employees and come out of the Fund. The 11% and 13% Surcharges therefore will necessarily increase the payments made from the Fund to Mutual of Omaha for health and hospital coverage for federal employees.

65. FEHBA, 5 U.S.C. § 8909(f)(1), provides:

> no tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or underwriting or plan

> administration subcontractor of an approved health benefits plan by any State . . . with respect to any payment made from the Fund.

66. To the extent they apply to payments made by the Fund to Mutual of Omaha pursuant to FEHBA plans underwritten by Mutual of Omaha, the 11% and 13% Surcharges constitute a monetary payment imposed by the State of New York on Mutual of Omaha as a carrier or underwriting subcontractor of an improved FEHBA health benefits plan.

67. Accordingly, insofar as Section 348 of the Act and Section 2807-C(1)(b) of the Statute apply surcharges to the payment rate for hospital care to patients covered by FEHBA plans, they are preempted under the Supremacy Clause of the Constitution of the United States and are invalid.

68. Plaintiff Mutual of Omaha is threatened with imminent irreparable injury.

69. Plaintiff Mutual of Omaha has no adequate remedy at law.

WHEREFORE, plaintiffs ask this Court for a judgment:

> (i) declaring that ERISA preempts Section 348 of the Act and renders it unenforceable insofar as it imposes the 11% Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;
>
> (ii) declaring that ERISA preempts Section 2807-(c)(1)(b) of New York's Public Health Law and renders it unenforceable insofar as it imposes the 13% Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;

(iii) declaring that ERISA preempts Section 346 of the Act and renders it unenforceable insofar as it imposes the HMO Surcharge on hospital bills for inpatient care provided to any participant in, or beneficiary of, an ERISA employee benefit plan;

(iv) declaring that FEHBA preempts Sections 346 and 348 of the Act, and Section 2807(c)(1)(b) of New York's Public Health Law, and renders them unenforceable insofar as they impose surcharges on hospital bills for inpatient care provided to any participant in, or beneficiary of, a FEHBA plan;

(v) permanently enjoining defendants from enforcing the laws which this Court has declared to be preempted and unenforceable as applied to ERISA employee benefit plan and FEHBA plan participants and beneficiaries;

(vi) awarding plaintiffs the costs of this action, including reasonable attorney's fees; and

(vii) granting such other and further relief as this Court may deem just and proper.

* * *

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Complaint of Plaintiff-Intervenor NYS Health Maintenance Organization Conference, et al., filed November 30, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

Plaintiffs, by their attorneys, Couch, White, Brenner, Howard & Feigenbaum, for their complaint, allege:

NATURE OF THE ACTION

1. This action seeks to invalidate a recently-enacted law of the State of New York on the grounds that it is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, which (with exceptions not applicable here) expressly supersedes all state laws and regulations "insofar as they . . . relate to any employee benefit plan" covered by ERISA.

2. Under the Omnibus Revenue Act of 1992 ("the Act"), New York imposes an assessment of up to 9% on the cost of inpatient hospital care of persons who belong to HMOs.

3. In New York, a substantial number of the persons subscribing to HMOs receive that coverage pursuant to employee benefit plans subject to ERISA. The primary effect of the 9% assessment is to increase the cost of benefits paid out by ERISA employee benefit plans that use HMOs to provide health coverage for their participants and beneficiaries.

4. The inevitable effect of the assessment is to increase the cost of employee benefit plans that contract with HMOs, reduce the coverage provided by such employee benefit plans, or force employers and plan administrators to choose other means for funding employee benefit plans. The assessment therefore will force employers or plan administrators to tailor their ERISA employee benefit plans to the peculiarities of New York law.

5. The 9% assessment has a direct and substantial effect upon ERISA employee benefit plans. Thus, it is a law that "relates to" employee benefit plans and is superseded by ERISA and rendered invalid under the Supremacy Clause of the United States Constitution.

JURISDICTION AND VENUE

6. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 in that the dispute arises under the Supremacy Clause of the Constitution of the United States, and the suit is also brought pursuant to 29 U.S.C. § 1132(a)(3). Plaintiffs seek declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202.

7. Venue is proper pursuant to 28 U.S.C. § 1391(b) and 29 U.S.C. 1132 (e) (2) in that defendants Salvatore R. Curiale and Robert Abrams reside in the Southern District of New York, a substantial part of the events giving rise to the claim have occurred and continue to occur in the Southern District of New York, and employee benefit plans that are the subject of this lawsuit are administered there.

PARTIES

8. Plaintiff, the New York State Health Maintenance Organization Conference ("NYSHMOC") , is an association of 27 health maintenance organizations ("HMOs"). In the aggregate, these HMOs serve approximately 2.5 million people in

57 counties in the State of New York. NYSHMOC represents the interests of HMOs and their members on matters of policy concerning health care.

9. HMOs are providers as well as insurers of health care. Individuals and families generally become members of HMOs by enrolling through their employer or union welfare fund. Other members join through direct pay, Medicare or Medicaid programs.

10. Plaintiff Capital District Physicians' Health Plan, ("CDPHP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, CDPHP provides health care and insurance for its own employees. In many cases, the benefits provided by Capital District Physicians' Health Plan are provided as part of an employee benefit plan.

11. Plaintiff ChoiceCare Long Island ("ChoiceCare") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, ChoiceCare provides health care and insurance for its own employees. In many cases, the benefits provided by ChoiceCare Long Island Plan are provided as part of an employee benefit plan.

12. Plaintiff Health Services Medical Corporation, ("HSMC") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its own members. In addition, HSMC provides health care and insurance for its own employees. In many cases, the benefits provided by HSMC are provided as part of an employee benefit plan.

13. Plaintiff Independent Health Association, Inc.,("Independent Health") is a not-for-profit corporation

certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Independent Health provides health care and insurance for its own employees. In many cases, the benefits provided by Independent Health are provided as part of an employee benefit plan.

14. Plaintiff Mid-Hudson Health Plan ("MHP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, MHP provides health care and insurance for its own employees. In many cases, the benefits provided by MHP are provided as part of an employee benefit plan.

15. Plaintiff MVP Health Plan, ("MVP") is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, MVP provides health care and insurance for its own employees. In many cases, the benefits provided by MVP are provided as part of an employee benefit plan.

16. Plaintiff Oxford Health Plans, ("Oxford") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Oxford provides health care and insurance for its own employees. In many cases, the benefits provided by Oxford Health Plans are provided as part of an employee benefit plan.

17. Plaintiff Physicians Health Services of New York ("PHS") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, PHS provides health care and insurance for its own employees. In many cases, the benefits provided by Physicians Health Services are provided as part of an employee benefit plan.

18. Plaintiff Preferred Care is a not-for-profit corporation certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Preferred Care provides health care and insurance for its own employees. In many cases, the benefits provided by Preferred Care are provided as part of an employee benefit plan.

19. Plaintiff Travelers Health Network of New York, Inc., ("Travelers") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, Travelers provides health care and insurance for its own employees. In many cases, the benefits provided by Travelers Health Network of New York are provided as part of an employee benefit plan.

20. Plaintiff U.S. Healthcare, is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition, U. S. Healthcare provides health care and insurance for its own employees. In many cases, the benefits provided by U.S. Healthcare are provided as part of an employee benefit plan.

21. Plaintiff Wellcare ("Wellcare") is an HMO certified pursuant to Article 44 of the Health Law, which provides health care and insurance benefits to its members. In addition Wellcare provides health care and insurance for its own employees. In many cases, the benefits provided by Wellcare are provided as part of an employee benefit plan.

22. Defendant Mark Chassin, M.D. is the Comissioner of Health of the State of New York. The Department of Health of the State of New York (the "Department of Health") is charged with administering the 13% surcharge imposed by the Statute and the 11% surcharge imposed by the Act. Defendant Chassin maintains an office at 125 Worth Street, New York, New York 10013.

23. Defendant Mary Jo Bane is the Commissioner of Social Services of the State of New York, and is charged with administering the surcharges on HMOs imposed by the Act. Defendant Bane maintains an office at 40 North Pearl Street, Albany, New York 12243.

24. Defendant Salvatore R. Curiale is the Superintendent of Insurance of the State of New York. Pursuant to Section 335 of the Insurance Law of the State of New York, defendant Curiale is empowered to prescribe and enforce rules and regulations governing insurance procedures that relate to the implementation of the hospital reimbursement provisions of the Public Health Law, including reimbursements giving rise to surcharges at issue in this litigation. Defendant Curiale maintains an office at 160 West Broadway, New York, New York 10013 which is his official residence.

25. Defendant Robert Abrams is the Attorney General of the State of New York, and is charged with enforcing compliance with the State's laws and regulations, including those at issue in this litigation, under New York Executive Law § 63 (1) and (12). The Attorney General maintains an office at 120 Broadway, New York, New York 10271 which is his official residence.

26. Defendant Mario M. Cuomo is the Governor of the State of New York, and is being sued in his official capacity as the Governor.

HMOs AND THEIR ROLE IN NEW YORK'S HEALTH CARE SYSTEM

27. HMO coverage differs from traditional health insurance. By combining hospitalization coverage with the provision of care, HMOs have the incentive to provide high quality health care in a cost efficient manner. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers

and hospitals. For example, some HMOs (group and staff models) employ their own physicians. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice and payment guidelines.

28. HMOs generally do not themselves provide in-patient hospital care. Rather, HMOs typically operate as third-party payors of in-patient hospitalization. The cost of hospital reimbursement is a substantial expense of the HMOs and therefore directly affects the cost of health care to employee health benefits plans for coverage of their employees.

29. In addition to being a provider of care, HMOs differ in other major respects from insurers. For example, unlike commercial insurers which have traditionally relied on experience rating, and unlike Blue Cross, which experience rates groups with more than fifty members, HMOs community rate everyone: large groups, small groups and individuals. HMOs also are required to open enroll all groups of five or more employees and last year served over 250,000 small group members.

30. HMOs are required by State law and regulations to offer a comprehensive benefits package. While each HMO's benefits package may have distinctive features, they all share an emphasis on primary and preventive care and cover a wide range of illnesses and conditions. Because of the State's regulatory requirements, HMOs may not revise their benefits packages at will and may not reduce their package beyond a certain level of benefits.

NEW YORK'S 9% ASSESSMENT ON HMOs

31. Under New York's Public Health Law, the State, with certain exceptions, requires hospitals to charge standardized payment rates for inpatient care. Public Health Law § 2807-c(1).

Under this system, medical procedures are divided into categories based on the patient's diagnosis, known as Diagnosis Related Groups ("DRG"s). Public Health Law § 2807-c(1) (a). Hospitals are required by law to charge, and payors are required to pay, the DRG rate applicable to an insured patient's diagnosis, as adjusted by a formula reflecting costs specific to each individual hospital.

32. Under Section 2807-c(1) (b) of the Public Health Law, the DRG rate is increased by a 13% surcharge imposed on payments for inpatient services to patients covered by commercially insured and self-insured employee benefit plans. HMOs, Blue Cross and government plans like Medicare and Medicaid do not pay the 13% surcharge. The funds generated by the 13% surcharge are retained by the hospital.

33. HMOs are also allowed by statute to negotiate alternative rates with hospitals. N. Y. Public Health Law § 2807-c(2) (b) (i) (McKinney Supp. 1992). HMOs' ability to negotiate rates reflects a recognition that HMOs' managed care systems are able to reduce significantly the cost of hospitalization.

34. Section 346 of the Act amends New York's Public Health Law to impose an assessment of up to nine percent on the cost of inpatient hospitalization provided by HMOs. Section 346 also provides that the assessment may be reduced or eliminated for HMOs that enroll a certain number of Medicaid recipients in a managed care plan.

35. Pursuant to Section 346, beginning on July 1, 1992, each HMO must pay the 9% assessment, on a monthly basis, directly into a statewide pool established by the Commissioner of Health. This amount is thereafter deposited into the State's General Fund. The funds are not paid to hospitals.

THE IMPACT OF THE 9% HMO ASSESSMENT

36. In developing their health care benefits packages, many employee health benefit plans seek to provide a choice between indemnity insurance and HMOs. In addition, State and federal law requires employers (and employee benefits plans) to offer their employees the choice of at least one HMO.

37. The cost of hospitalization is approximately 30-40% of the overall cost of the HMO. Thus, the 9% HMO assessment raises the cost of providing health coverage through an HMO by as much as 3-4%. In the aggregate, the State projects that the 9% will generate approximately $32 million in the 1992-93 fiscal year. The HMO assessment thus directly increases the cost of providing hospital care to certain HMO subscribers enrolled pursuant to employee benefit plans.

38. As a result of the HMO assessment, administrators of employee benefit plans providing health care in whole or in part through an HMO (including plans covering employees of the intervenor HMOs) will be forced to pay more for HMO coverage or accept reduced HMO benefits. The HMO assessment therefore forces administrators or fiduciaries of employee benefit plans providing health and hospital coverage through an HMO, including plans covering employees of the intervenor HMOs, to tailor their ERISA plans to the peculiarities of New York law.

COUNT ONE

(ERISA PREEMPTS THE HMO ASSESSMENT)

39. Plaintiffs reallege each and every allegation contained in paragraphs 1 through 38 above.

40. Section 346 of the Act, which imposes the HMO assessment, is a law that "relates to [an] employee benefit plan" within the meaning of 29 U.S.C. § 1144(a).

41. None of the exceptions to the preemption provisions of 29 U.S.C. § 1144(a) apply, and, accordingly, section 346 of the Act is preempted under the Supremacy Clause of the Constitution of the United States and is invalid.

42. Plaintiffs are threatened with imminent irreparable harm.

43. Plaintiffs have no adequate remedy at law.

WHEREFORE, plaintiffs ask this Court for a judgment:

(i) declaring that ERISA preempts section 346 of the Act and renders it unenforceable insofar as it imposes a 9% assessment on the cost of inpatient care provided by an HMO to any participant in, or beneficiary of, an ERISA employee benefit plan;

(ii) permanently enjoining defendants from enforcing the laws which this Court has declared to be preempted and unenforceable as applied to ERISA employee benefit plan participants and beneficiaries;

(iii) awarding plaintiffs the costs of this action, including reasonable attorney's fees; and

(iv) granting such other and further relief as this Court may deem just and proper.

* * *

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James M. Gutterman, filed August 21, 1992

[Travelers Ins. Co. v. Cuomo]

* * *

JAMES M. GUTTERMAN, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for inpatient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore F. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Division Vice President and Actuary, Managed Care and Employee Benefits. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers and the types of services which The Travelers provides to both insured and self-insured group health plans.

3. The Travelers and its affiliated and subsidiary companies constitute one of the world's largest multi-line insurance, financial and health services institutions. Among other services, The Travelers provides group accident and health insurance which it markets through group contracts to employers, employer associations and trusts, and other organizations ranging in size from small local employers to large multinational corporations. Under a typical group policy, the benefits provided by The Travelers include reimbursement of hospital, surgical and medical expenses, including coverage for inpatient hospital care. The Travelers also provides claims administration services for employer plans which are self-insured. With regard to the handling of claims for many such plans—both insured and self-insured—The Travelers is a fiduciary within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. § 1002(21)(A).

4. In New York State, The Travelers provides either claims administration services or group accident and health insurance to over 430,000 employees and dependents covered by ERISA plans. The Travelers provides the above services or insurance in connection with 4,429 separate ERISA plans.

5. Under Section 2807-c of the New York Public Health Law, the rate of payment to general hospitals for inpatient hospital care in New York is regulated. Except in cases such as that of an uninsured person, the rates for inpatient hospital care are generally set on the basis of categories relating to the diagnosis of illness, known as diagnosis related groups or DRG's. Under the system, the amount charged for inpatient hospital care is set on the basis of the DRG into which the patient falls, rather than the actual cost of the treatment. In addition, as described below, the DRG amount is multiplied by a "payor factor" which creates a differential among the amounts charged to various payors such as a self-insured plan, health maintenance organization, commercial insurance company or a Blue Cross company. Under Section 2807-c(1)(b), the rate of general hospital reimbursement for patients "enrolled in a self-insured fund which provides for reimbursement directly to general hospital on an expense-incurred basis" is 113% of the applicable DRG rate. Thus, self-insured funds pay a surcharge of 13%, over and above the applicable DRG rate.

6. Under Section 2807-c(1) (b), as amended by Section 348 of the Omnibus Tax Revenue Act of 1992, the rate of general hospital reimbursement for a person "insured under a commercial insurer licensed to do business in [New York] and authorized to write accident and health insurance and whose policy provides inpatient hospital coverage on expense-incurred basis, and the insurer makes payments directly to the general hospital" is 124% of the applicable DRG rate. Thus, commercial insurers pay an aggregate surcharge of 24% over and above the applicable DRG rate. This aggregate consists of the 13% surcharge required by Section 2807-c(1)(b) of the Public Health Law, plus an additional 11% surcharge required by Section 348 of the newly-enacted Omnibus Tax Revenue Act of 1992.

7. The Travelers provides claims administration services in connection with 92 separate self-insured plans, providing benefits to over 280,000 persons subject to the 13% surcharge under Section 2807-c(1)(b). Ninety-one of these plans, providing benefits to 279,000 persons, are subject to ERISA. The Travelers provides health insurance, including coverage for inpatient hospital care, to 215,000 persons who are subject to the 24% surcharge under Section 2807-c(1)(b). Over 150,000 persons receive such coverage pursuant to 4,338 separate plans which are subject to the terms of ERISA. Thus, based on the experience of The Travelers, the vast majority of persons subject to the surcharges at issue are covered by an ERISA plan.

8. Many of the employers purchasing either claims administration services or group accident and health insurance from The Travelers operate and provide benefits to employees in more than

one state. The Travelers provides group accident and health insurance and/or claims administration services in connection with hundreds of ERISA plans which cover employees in both New York and other states. In many of the other states, the state does not require that a hospital charge different rates for inpatient hospital care provided to a person covered by commercial insurance or a self-insured plan.

9. The premiums charged by The Travelers for group insurance coverage reflect assumptions as to claims, investment returns and expenses, and a profit margin. As the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the cost through to the employer by increasing the premium. Similarly, in the case of a self-insured plan, as the cost of the covered treatment increases, the amount of the claims administered by The Travelers and paid by the employer increases.

10. In addition to its group accident and health policies, The Travelers also provides excess risk insurance to self-insured group accident and health plans, which is known in the insurance industry as stop-loss coverage. Many self-insured ERISA plans purchase some form of stop-loss coverage to insure against catastrophic loss. The stop-loss policies issued by The Travelers usually provide either individual stop-loss coverage, aggregate stop-loss coverage or both. Under an individual stop-loss provision, The Travelers provides coverage only if the benefits paid by the plan during a policy year to any one individual exceed a specified individual trigger amount, which is set in the policy. Under an aggregate stop-loss provision, The Travelers provides coverage only if the aggregate benefits paid during the policy year exceed an aggregate trigger amount, which is set in the policy. Some of the stop-loss policies issued by The Travelers contain both individual and aggregate stop-loss provisions.

11. Under a stop-loss policy, until the amount of benefits paid by the plan exceeds the applicable trigger amount, The Travelers has no obligation to make payments to the plan. If and when the benefits exceed the applicable trigger amount, The Travelers is obligated under the policy to reimburse the employer for the amount of payments above the trigger amount. However, unlike a group insurance policy, The Travelers has no obligation to the employees or their dependents. In many instances, particularly with respect to aggregate stop-loss, the stop-loss programs administered by The Travelers operate for years without paying benefits over the applicable trigger amount.

12. B.H. Aircraft Company, Inc. ("B.H. Aircraft") is a New York corporation with its principal place of business in Farmingdale, New York. B.H. Aircraft is in the business of manufacturing aircraft parts, and conducts its operations in New York.

13. B.H. Aircraft provides group accident and health insurance to 122 employees under a plan which is subject to ERISA (the "B.H. Plan"). The Travelers has issued a policy to B.H. Aircraft which provides accident and health insurance to B.H. Aircraft's employees and their dependents (the "B.H. Policy") (a copy of the B.H. Policy is annexed hereto as Exhibit A). The B.H. Plan and the B.H. Policy provide coverage to 121 employees of B.H. Aircraft in New York and one employee in Connecticut. The Travelers pays claims made by employees of B.H. Aircraft and their dependents. With regard to the adjudication of such claims, The Travelers is a fiduciary of the B.H. Plan within the meaning of Section 3(21)(A) of ERISA, 29 U.S.C. §1002(21)(A).

14. The B.H. Policy includes coverage for the amount charged to an employee for inpatient hospital care. The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital care. The 24% surcharge will undoubtedly increase the amount of the premium charged for group accident and health insurance for the

beneficiaries of the B.H. Aircraft Plan. The B.H. Policy is typical of the group accident and health insurance policies which The Travelers issues to employers in the State of New York.

15. Sheridan Catheter Corporation ("Sheridan Catheter") is a New York corporation with its principal place of business in Argyle, New York. Sheridan Catheter produces medical equipment and supplies. Its operations are conducted in New York, but Sheridan Catheter has sales employees located in the states of California, Georgia, Illinois, Maryland, Missouri, Ohio, Pennsylvania, Tennessee, Texas and Washington.

16. Sheridan Catheter has 242 employees. Two hundred and thirty-two of these employees are located in New York and the remaining ten are located in the other states listed in the foregoing paragraph. Sheridan Catheter provides group accident and health coverage for its employees under an employee welfare benefit plan (the "Sheridan Catheter Plan") subject to ERISA. Among other things, this plan provides coverage to Sheridan Catheter's employees for inpatient hospital care.

17. The Sheridan Catheter Plan is self-insured. The plan is funded by contributions from Sheridan Catheter itself, as well as periodic deductions from the pay of its employees. Thus, when a covered employee is reimbursed for the cost of inpatient hospital care, for example, this reimbursement is funded by Sheridan Catheter and its employees, rather than by an insurance company.

18. Sheridan Catheter has contracted with The Travelers to provide claims administration services. The applicable contract is known as an "Administrative Services Only" Agreement.

19. A copy of the Administrative Services Only Agreement currently in force between Sheridan Catheter and The Travelers is annexed hereto as Exhibit B. Pursuant to this Agreement, requests for benefit payments are made to The Travelers, which

then determines entitlements to plan benefits in accordance with the plan. Sheridan Catheter, however, must establish and maintain during the life of the Administrative Services Only Agreement (and for a reasonable period of time following its termination) a bank account for the payment of benefits to plan members. While The Travelers prepares the checks representing benefit payments made pursuant to the plan, it is Sheridan Catheter's responsibility to fund the bank account on which these checks are drawn.

20. To protect itself from catastrophic loss, Sheridan Catheter has purchased an excess risk contract from The Travelers, which is known in the industry as a stop-loss contract. A copy of the stop-loss contract currently in force between Sheridan Catheter and The Travelers is annexed hereto as Exhibit C.

21. Sheridan Catheter's stop-loss contract provides both individual and aggregate stop-loss coverage. Under the aggregate excess risk benefit provision of the contract, The Travelers' obligation to provide coverage is triggered only if the aggregate benefits paid by Sheridan Catheter during the applicable contract period exceed 125% of annual anticipated health care claims.

22. Under the individual excess risk benefit provision of the stop-loss contract, The Travelers provides coverage only in the event the benefits paid by Sheridan Catheter during the applicable policy period for any one employee or dependent exceed $90,000.

23. Unless the aggregate or individual excess risk benefit provisions are triggered, The Travelers simply administers claims on Sheridan Catheter's behalf using funds provided by Sheridan Catheter.

24. Pursuant to the terms of Sheridan Catheter's stop-loss contract, even when these points are reached, The Travelers has

no obligation to pay benefits to Sheridan Catheter employees. Instead, The Travelers reimburses Sheridan Catheter for the amount of payments above the applicable trigger amount.

25. Obviously, the 13% surcharge increases the amount of benefits the Sheridan Catheter Plan pays out. But this is not all. By increasing the amount of benefits Sheridan Catheter pays out, the administrative service charge due The Travelers is also increased. The Administrative Services Only Agreement specifically provides that Sheridan Catheter's monthly administrative service charge "shall be the sum of (1) 10.79% of the dollar amount of the drafts which would be issued by The Travelers pursuant to [the Administrative Services Only] Agreement, if the coordination of benefits provision were not applicable; and (b) 4.5% of the benefit payment reductions resulting from the application of the coordination of benefits provision of the Plan." Thus, the Administrative Services Only Agreement ties Sheridan Catheter's administrative service charge, in part, to the dollar amount of the drafts issued by The Travelers in a certain period of time. These drafts increase in dollar amount as hospital reimbursement rates rise due to added surcharges. It follows that adding surcharges to the rate of reimbursement for inpatient hospital care increases the periodic administrative service charge Sheridan Catheter must pay The Travelers.

26. The Sheridan Catheter Policy is typical of the stop-loss policies issued by The Travelers in order to provide excess risk insurance to self-insured plans. An employer's purchase of excess risk insurance to protect against catastrophic loss does not alter the fact that the plan is essentially self-insured.

WHEREFORE, it is respectfully submitted that The Travelers' motion for summary judgment should be granted.

JAMES M. GUTTERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Thomas D. Musco, filed August 21, 1992

[HIAA v. Chassin]

* * *

THOMAS D. MUSCO, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Director of Statistics of The Health Insurance Association of America ("HIAA"). In that capacity, I am responsible for data collection and analysis through surveys of HIAA's member companies. I have been employed at HIAA for 21 years. I am fully familiar with the facts set forth below.

2. HIAA is a trade association organized to promote and protect the interests of its members, which are commercial writers of health insurance throughout the United States. According to the most recent data available to me, HIAA represents the interests of approximately 300 member companies that provide health coverage to approximately 85 million people in the United States.

3. On information and belief, HIAA's members also issue the great majority of the commercial group health insurance policies in the State of New York.

4. Employers who establish employee welfare benefit plans subject to the Employment Retirement and Income Security Act ("ERISA") provide health and hospital coverage to their em-

ployees by a variety of methods, including: (i) commercial health insurance policies; (ii) self-insurance (in which the plan is directly responsible for medical and hospital bills and may or may not carry excess liability coverage); (iii) subscriptions to a health maintenance organization ("HMO"); or (iv) coverage through a non-profit health insurer such as Blue Cross.

5. An ERISA plan using commercial health insurance contracts with an insurer which reimburses certain health care costs incurred by plan participants and their beneficiaries, in exchange for a premium calculated to cover the costs of paying claims and administering the policy.

6. ERISA plans that are self-insured directly assume responsibility for the costs of health care, including inpatient hospital care, for their participants. Under some self-insured plans, the employer covers the full cost of the covered health care, while in other instances contributions from employees are required. Employers frequently retain a commercial insurer to administer claims and perform other administrative functions for self-insured plans.

7. An HMO provides subscribers with comprehensive health care, including inpatient hospital coverage, from its designated providers for a predetermined periodic payment. Employers frequently contract with HMOs to provide medical coverage to employee welfare plan participants who choose to enroll in HMOs.

8. Blue Cross corporations are non-profit corporations organized under Article 43 of the New York Insurance Law which are distinguished from commercial health insurers under New York law.

9. Based on information provided to HIAA by our member organizations and on my experience in the industry, the vast

majority of the individuals who are covered by commercial health insurance in New York, as in the rest of the United States, are covered pursuant to employee benefit plans as defined by ERISA.

10. An independent study published earlier this year shows that of 158.3 million non-elderly Americans who have private health insurance, 138.7 million, or nearly 88%, receive such coverage through their employers. *See* Exhibit A attached hereto, excerpt from Foley, *Sources of Health Insurance and Characteristics of the Uninsured* (Employee Benefit Research Institute 1992).

11. Based on information provided to HIAA by its member organizations, many of the employee benefit plans that purchase commercial health insurance from members of HIAA to cover employees in New York also cover employees in other states.

12. HIAA is itself the fiduciary for an employee benefit plan subject to ERISA covering its own employees that provides commercially insured health and hospital coverage to former HIAA employees in New York State and to present and former employees in other states and the District of Columbia.

13. Many of HIAA's members also serve as claims administrators and claims fiduciaries for self-insured ERISA plans that provide inpatient hospital coverage to plan beneficiaries. Based on information provided to HIAA by its members, and my knowledge of the industry, some of the self-insured plans cover employees in states other than New York as well.

14. Based on my knowledge of the industry, most self-insured plans are employee benefit plans subject to ERISA.

15. Some of HIAA's members also own, in whole or in part, HMOs, organized pursuant to Article 44 of New York's Public Health Law. Based on my knowledge of the industry, such HMOs provide full health coverage, including coverage of inpatient

hospital care, to subscribers, many of whom are enrolled pursuant to employee benefit plans.

THOMAS D. MUSCO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Vincent W. Donnelly, filed August 21, 1992

[HIAA v. Chassin]

* * *

VINCENT W. DONNELLY, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am an actuary with the American Council of Life Insurance ("ACLI"). In that capacity I have been employed with ACLI for 17 years, with my primary responsibility in the area of group insurance. Prior to my employment with ACLI, I was employed for fifteen (15) years by three life insurers, having various group insurance actuarial responsibilities with each insurer. I am fully familiar with the facts set forth below.

2. ACLI is a trade association representing 611 companies, of which 125 are licensed to do business in New York.

3. ACLI's members, many of which also belong to Health Insurance Association of America (HIAA), write approximately 95% of the life insurance and about 80% of the commercial health insurance policies currently purchased in the United States and in the State of New York.

4. Based on my knowledge of the industry, the vast majority of individuals who are covered by commercial health insurance or

self funded plans receive such coverage through employer plans covered by ERISA.

5. ACLI itself is the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to certain ACLI and HIAA employees and their dependents in New York, as well as to ACLI employees and their dependents in other states and the District of Columbia.

6. Some of ACLI's members serve as claims administrators and claims fiduciaries for certain self-funded ERISA plans in New York.

7. Some of ACLI's members also own, in whole or in part, health maintenance organizations ("HMO"s) organized pursuant to Article 44 of New York's Public Health Law. Such HMOs provide full health coverage, including coverage of in-patient hospital care, to subscribers. Based on my knowledge of the industry most HMO subscribers are enrolled pursuant to employee benefit plans subject to ERISA.

VINCENT W. DONNELLY

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Raymond A. D'Amico, filed August 21, 1992

[HIAA v. Chassin]

* * *

RAYMOND A. D'AMICO, being sworn, states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Senior Vice President and General Counsel of the Life Insurance Council of New York ("LICONY"). In that capacity, I am fully familiar with the facts set forth below.

2. LICONY is a trade association with 64 members organized to promote and protect the interests of its members—commercial writers of life insurance in the State of New York—some of which write health insurance policies.

3. On information and belief, LICONY's members—most of which also belong to the Health Insurance Association or the American Council of Life Insurance—write a significant percentage of the commercial health insurance policies in New York State, most of which are purchased pursuant to employee benefit plans. Some of those employee benefit plans are multi-state plans that cover employees in other states as well as employees in New York.

4. In addition, LICONY's members serve as claims administrators and claims fiduciaries for self-insured ERISA employee welfare benefit plans in New York. Some of those self-insured employee benefit plans are multi-state plans covering employees in New York and other states.

5. Two of LICONY's members own, in whole or in part, health maintenance organizations ("HMO"s) which provide health and hospital coverage to subscribers. On information and belief, those HMOs enroll a large number of subscribers pursuant to employee benefit plans.

6. LICONY is itself the fiduciary for an employee benefit plan that provides commercially insured health and hospital coverage to LICONY's employees in New York.

RAYMOND A. D'AMICO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Mark R. Welch, filed August 21, 1992

[HIAA v. Chassin]

* * *

Mark R. Welch, being sworn, states:

1. I am Director of the unit within the Actuarial Department of Aetna Life Insurance Company that has responsibility for financial arrangements and risk policy with respect to health coverage issued by Aetna Life to sponsors of large employee benefit plans. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The statements in this affidavit are based on my personal knowledge and on business records of Aetna Life.

2. Aetna Life is a commercial insurance company authorized to do business in New York, and in all of the fifty States. Aetna Life insures or administers health care coverage for participants in employee benefit plans nationwide.

3. Employee benefit plans use various methods to provide coverage to their participants, including self-insurance and commercial insurance.

4. A self-insured employee benefit plan retains responsibility for providing funds to pay charges for medical care, including inpatient hospital care, furnished to participants in the plan. Frequently, such a plan retains a third party, such as an insurance

company, to administer the claims and to perform other related services. The sponsor of a self-insured plan may also purchase contractual liability insurance—which has come to be known in the industry as "stop-loss" coverage—entitling it to reimbursement from the insurer if the plan's claims exceed specified limits.

5. Alternatively, an employee benefit plan may choose to purchase commercial insurance to provide health benefits, including hospital coverage, to plan participants. When a plan is fully insured, the insurance company is responsible for funding all benefits. A hybrid arrangement (known as a "split-funded" arrangement) combines elements of self-insurance and insurance. An insurance policy outlines the insurer's liability under the arrangement, but there is also an administrative services agreement under which the employer is responsible for funding claims up to a maximum limit—in effect, a deductible under the insurance policy—with the insurer funding claims above the limit.

6. Aetna Life does business with both self-insured and commercially-insured plans covering participants in New York State. Specifically, Aetna Life sells claims administration and other services to self-insured employee benefit plans pursuant to administrative services contracts and sells commercial group health insurance to fully insured and split-funded plans. Administrative services contracts and commercial insurance policies issued to plans with more than 200 eligible employees cover approximately 1,020,000 individuals (employees and dependents) in New York.

7. I am advised that church plans and governmental plans are exempt from the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* ("ERISA"). Of the 189 plans covering 200 or more eligible employees that were issued by Aetna offices responsible for New York State, less than 2% cover exempt church and governmental plans. Thus, it is my understanding that almost all of the plans for which Aetna Life provides administrative services or insurance are ERISA plans, and

that the great majority of individuals in New York State with respect to whom Aetna Life either issues commercial insurance or provides administrative services obtains health coverage through employee benefit plans covered by ERISA.

8. The plans for which Aetna insures or administers various forms of health coverage include a number of plans that have participants both in New York and in other states. For instance, Aetna administers coverage for approximately 46,000 employees of a large New York-based company, fewer than 10% of which are located in New York.

9. When the sponsor of an employee benefit plan purchases an administrative services contract from Aetna Life, the sponsor may elect to make final benefit determinations and to review claims for denied benefits, or it may choose (for a fee) to delegate those responsibilities to Aetna Life or to another third party. When the plan sponsor chooses the second option, Aetna Life acts as the plan's claims fiduciary for purposes of ERISA. Approximately 30-40% of the sponsors of self-insured plans covering participants in New York and administered by Aetna Life—including most of the largest such plans—have elected to designate Aetna as their claims fiduciary.

10. When Aetna Life issues commercial insurance covering members of an employee benefit plan, it is responsible for making final benefit determinations and reviewing claims for denied benefits. Accordingly, for purposes of ERISA, Aetna Life acts as the claims fiduciary with respect to the plan.

11. As noted, a self-insured employee health plan bears the full cost of providing plan participants with covered medical care, including charges for in-patient hospital care (although it may be reimbursed for claims exceeding the limit of any stop-loss coverage it may have purchased). Accordingly, the 13% surcharge that New York State imposes on in-patient hospital charges increases the amount that self-insured benefit plans must pay to provide

plan participants with benefits. The surcharge also increases the amount the plans must pay for stop-loss coverage. Because that coverage is rated on a regional basis (with New York and vicinity treated as a region), premiums for stop-loss coverage reflect the increased costs resulting from the 13% surcharge on hospital benefit payments.

12. The 13% surcharge and the 11% surcharge that New York has imposed on charges for in-patient care provided to patients with commercial insurance also increase the amounts that sponsors of plans to which Aetna Life has issued commercial insurance must pay for that coverage. Indeed, coverage for almost all plans with 200 or more eligible employees is provided under agreements that tie the plan sponsor's costs directly to the amounts actually paid for benefits to plan participants.

13. Those plans that are covered under split-funded arrangements bear the cost of the surcharges up to the limit of claims that are funded by the plan sponsor. In addition, commercial insurance, including the insured portion of a split funded arrangement, is usually provided to plans with 200 or more participants on what is known as an "experience-rated" basis. When an insured health plan is experience rated on a stand alone basis, the premium is dependent upon the amount paid to provide benefits to participants in that plan. If the total insured claims paid out under the policy at the end of the policy year and other costs of providing the insurance (including a certain level of profit) are less than the amount of the premium the plan has paid, the plan is eligible for a refund. If, however, the premium paid is less than the total of the insured claims paid and other expenses, there is a deficit, and the premium for the following year is adjusted to make up the shortfall. Under those arrangements, the burden imposed by the 11% and 13% surcharges is imposed directly on the employee benefit plan.

14. I am informed that certain plans for which Aetna Life has provided coverage have changed the form of their coverage in response to the 11% surcharge. Some have changed from a fully-

insured or partially-insured arrangement to an administrative services contract to avoid the surcharge.

MARK R. WELCH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of John P. Burke, filed August 21, 1992

[HIAA v. Chassin]

* * *

John P. Burke, being sworn, states:

1. I am Financial Officer of the unit that sells group insurance (including health insurance) issued by Aetna Life Insurance Company primarily for employee benefit plans with fewer than 200 eligible employees. In that position, I participate in setting the premiums that Aetna Life charges for group health insurance covering those plans in New York State and elsewhere. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The facts set forth below are based on my personal knowledge and on business records of Aetna Life.

2. In New York State, Aetna Life provides health coverage to approximately 1000 employee benefit plans with fewer than 200 eligible employees. Those plans cover approximately 32,000 employees and their dependents.

3. I am advised that church plans and governmental plans are exempt from the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001 *et seq.* ("ERISA"). I have reviewed a list of the plans with fewer than 200 eligible employees that are covered by commercial insurance issued by Aetna Life in New York State. Of the plans listed, fewer than 3% are churches or

governmental subdivisions. It is my understanding that the remainder are ERISA plans and thus, that the great majority of the individuals covered by Aetna Life's commercial insurance for groups of fewer than 200 eligible employees obtains that coverage through employee benefit plans covered by ERISA.

4. A number of those plans cover employees both in New York and in other States. For instance, plans for employees of Kason, Industries, Inc., Anco Engineers, Inc., and Wieland, Inc., among others, include employees in New York and other States.

5. When Aetna Life has sold commercial health insurance to the sponsor of an employee benefit plan, Aetna Life is responsible for making final benefit determinations and reviewing claims for denied benefits. Accordingly, my understanding is that Aetna Life serves as a claims fiduciary for those plans that are covered by ERISA.

6. Virtually all of the health coverage issued by Aetna Life in New York to sponsors of plans with fewer than 200 eligible employees is fully insured and prospectively rated. That is, the policies are written without employer self-insurance, and the premiums are set for the term of the policy, but may be increased when the policy is renewed.

7. In New York State, the premium that Aetna Life charges to a sponsor of a plan with fewer than 200 eligible employees for group health insurance is based, in large part, on the amount of claims made by participants in the plan in preceding policy periods (within limits allowed by New York State law), the amount of the claims by participants in other similar plans in the same area within the State, and anticipated changes in the costs of health care. Accordingly, increases in the amount paid for health care have a substantial effect on the premiums charged. In New York State, charges for in-patient hospital services make up about 35% of the total cost of claims covered by Aetna Life's group health insurance. Consequently, the 13% surcharge that New

York State imposes on in-patient hospital charges is reflected in the premiums charged by Aetna Life for commercial health insurance, and, as policies are renewed, the newly-enacted 11% surcharge puts upward pressure on those premiums.

JOHN P. BURKE

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Robert B. Shapland, filed August 21, 1992

[HIAA v. Chassin]

* * *

Robert B. Shapland, being sworn, states:

1. I submit this affidavit in support of plaintiff's motion for summary judgment. I am Vice President and Actuary of Mutual of Omaha Insurance Company ("Mutual of Omaha"), a mutual insurance company authorized to do business in the State of New York and in all of the 50 states. In my actuarial capacity, I am fully familiar with the facts set forth below.

2. In 1992, Mutual of Omaha wrote commercial health and accident coverage with allocable premiums in New York State of $99,401,907, including policies covering inpatient hospital charges on an expense-incurred basis.

3. In contrast to many large health insurers, the majority of individuals receiving health and accident coverage from Mutual of Omaha in New York are covered through individual insurance or through other plans not subject to ERISA. Nonetheless, the proportion of persons covered by Mutual of Omaha pursuant to ERISA Employee Welfare Benefit Plans is not insignificant (representing approximately 27% of premium volume).

4. Mutual of Omaha provides commercial insurance in New York to approximately 1,000 employee benefit plans, the vast

majority of which are subject to ERISA. Said plans cover approximately 23,500 employees and their covered dependents.

5. Mutual of Omaha also issues commercial insurance to employee benefit plans in states other than New York, which cover employees in New York. Conversely, many of the employee benefit plans purchased in New York cover persons employed in or residing in other states.

6. Mutual of Omaha has final authority to make claims decisions and thus, is a claims fiduciary for the commercial health and accident insurance plans it issues to employee benefit plans subject to ERISA both in New York and elsewhere.

7. Mutual of Omaha needs to charge higher premiums for commercial health and accident insurance issued in New York State and elsewhere as a result of the surcharges New York has imposed on hospital bills covered by commercial insurance.

8. Mutual of Omaha is itself the plan sponsor and is also a fiduciary for a self-insured employee benefit plan that provides health and accident coverage, including expense-incurred hospital coverage, to employees of Mutual of Omaha (and its subsidiaries and affiliates) residing in New York. This plan also covers Mutual of Omaha's employees in other states. As plan sponsor, Mutual of Omaha makes determinations on various issues affecting the plan including benefit level, continuation of the plan, and decisions on funding such as whether to utilize commercial insurance or self-insurance.

9. The 13% surcharge imposed by Section 2807-c(1)(b) of New York's Public Health Law directly increases the cost of covering claims under Mutual of Omaha's self-insured plan.

ROBERT B. SHAPLAND

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James R. Hibbitts, filed August 21, 1992

[HIAA v. Chassin]

* * *

JAMES R. HIBBITTS, being sworn states:

1. I submit this affidavit in support of plaintiffs' motion for summary judgment. I am the Vice President of Group Administration of The Union Labor Life Insurance Company ("Union Labor"), a commercial insurance company licensed to do business in New York and in all 50 states. In that capacity I am in charge of managing Union Labor's entire group life and health insurance operation, which primarily markets employee benefit plans subject to ERISA. I am fully familiar with the facts set forth below.

2. Union Labor has in force group health insurance coverage policies containing hospital coverage issued to employee benefit plans located in New York State.

3. Some of those plans are multi-state plans that cover employees in other states as well as in New York.

4. Union Labor is itself the fiduciary for a commercially-insured employee benefit plan that provides health and hospital coverage to employees of Union Labor and its affiliates residing

in New York. That plan also covers Union Labor's employees in other states and the District of Columbia.

JAMES R. HIBBITTS

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Thomas L. Reddy, Sr., filed August 21, 1992

[HIAA v. Chassin]

* * *

THOMAS L. REDDY, SR., being sworn, states:

1. I submit this affidavit in support of plaintiffs' notion for summary judgment. I am the Chairman of the Board of Trustees of the Professional Insurance Agents of New York, Inc. Trust ("PIA Trust"). In that capacity, I am fully familiar with the facts set forth below.

2. PIA Trust is the fiduciary for a commercially-insured employee welfare benefit plan subject to ERISA that provides benefits, including health and hospital coverage, to members of the Professional Insurance Agents of New York State and to similar groups in New Jersey and Connecticut.

3. The Board of Trustees of PIA Trust has responsibility for determining the form and scope of coverage provided by the Trust to its beneficiaries.

4. PIA Trust provides health and hospital coverage for approximately 4,000 plan beneficiaries in New York State and approximately 5,600 plan beneficiaries in New Jersey and Connecticut.

5. The 13% and 11% surcharges imposed under New York's Public Health Law on bills for in-patient hospital care covered by commercial insurance will inevitably increase the cost of premiums for health insurance to cover health and hospital care for the beneficiaries of PIA Trust in New York State by 24%.

THOMAS L. REDDY, SR.

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Angelo V. D'Ascoli, filed August 21, 1992

[HIAA v. Chassin]

* * *

Angelo V. D'Ascoli, being sworn, states:

1. I am Executive Director of Aetna Health Plans of New York, Inc. ("Aetna Health Plans"), a health maintenance organization that is licensed under Article 44 of New York's Public Health Law to do business in that State. I am responsible for overseeing Aetna Health Plans' operations. I am submitting this affidavit in support of the plaintiffs' motion for summary judgment. The facts stated below are based on my personal knowledge and business records of Aetna Health Plans.

2. Aetna Health Plans provides health coverage, including in-patient hospital benefits, to its 11,700 members in New York. Over 99% of those members have been enrolled pursuant to agreements between Aetna Health Plans and employers sponsoring employee benefit plans. Under those agreements, the employer agrees to pay a specified rate for each employee who enrolls in Aetna Health Plans (plus, if the employee elects and the plan permits, an additional amount to cover dependents).

3. Some of the employee benefit plans whose New York participants may enroll in Aetna Health Plans also include participants in other States. For instance, enrollment in Aetna Health Plans is

offered as an option to participants in Aetna Life's multi-state plan who reside in Aetna Health Plans' service area.

4. I am advised that governmental plans and church plans are exempt from the Employee Retirement Income Security Act of 1974 ("ERISA"). Only 1.7% of Aetna Health Plans' members are participants in governmental plans; none of its members are participants in church plans. It is my understanding, therefore, that the remainder are members of ERISA plans.

5. Aetna Health Plans is responsible for making final benefit determinations and reviewing claims for denied benefits by its members. Accordingly, my understanding is that Aetna Health Plans acts as claims fiduciary, for purposes of ERISA, with respect to those members who are covered by that statute.

6. Aetna Health Plans is subject to the 9% surcharge imposed by Section 346 of New York's Omnibus Revenue Act of 1992 on charges for in-patient hospital services rendered to HMO subscribers.

7. Rates charged by Aetna Health Plans are subject to prior approval by New York's Department of Insurance. In its applications for rate approval, Aetna seeks rates calculated to recover its health-care costs (hospital costs, physician costs, and miscellaneous medical costs), administrative costs, and some profit. The overwhelming majority (about 80%) of those items is the actual cost of health services, and in-patient hospital charges account for approximately 35% of that cost. Thus, the 9% surcharge will significantly increase the amount Aetna Health Plans must charge to recover its costs.

ANGELO V. D'ASCOLI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Steven C. Anderman, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STEVEN C. ANDERMAN, being duly sworn, deposes and says:

1. I am a Deputy Director of the Office of Health Systems Management ("OHSM"), New York State Department of Health ("Department"). I have supervisory responsibility over OHSM's Division of Health Care Financing, including the hospital reimbursement rate setting process, and I am accordingly familiar with the facts hereinafter set forth. I make this affidavit in opposition to plaintiffs' motions for summary judgment and for a preliminary injunction and in support of defendants' cross-motion for summary judgment.

INTRODUCTION

2. Plaintiffs allege that certain provisions of New York Public Health Law ("PHL") -2807-c are preempted by the federal Employee Retirement Income Security Act ("ERISA") and/or the Federal Employee Health Benefits Act ("FEHBA"). The challenged provisions are: (a) the 13% differential hospitals are generally required to apply to the inpatient hospital bills of patients covered by third party payors other than Medicare, Medicaid, health maintenance organizations ("HMO's"), and/or Blue Cross

plans (-2807-c(1)(b)), (b) the additional 11% differential hospitals are required to bill for patients covered by commercial health insurance carriers (-2807-c(11)(i)), and, (c) the contingent variable differential (0% to 9%) hospitals are required to bill for patients covered by HMO's (-2807-c(2-a)).

3. Plaintiffs claim that these differentials are preempted by ERISA because they increase the prices hospitals charge patient beneficiaries of plaintiffs' ERISA plan customers and thus tend to increase the health coverage costs of such ERISA plans. It is the Department's position, as set forth below in more detail, that these differentials are essential to promote important social policy goals relating to health care and that the tenuous and remote impact on the cost of benefits of ERISA plans is an insufficient basis for invoking preemption under ERISA. In regard to plaintiffs' FEHBA claim, I am advised by counsel that, contrary to plaintiffs' assertions, FEHBA's prohibition on any state "tax, fee, or other monetary payment" on payments made by FEHBA funds for health insurance coverage has no relevance or applicability to the differentials at issue herein.

HOSPITAL REIMBURSEMENT

4. Hospitals receive revenue for inpatient services from a number of sources. The largest payors in the system are Medicare, Medicaid and Blue Cross plans. Other payors include HMO's, commercial health insurance carriers, self-insured funds, the workers compensation and "no-fault" automobile insurers, and individual "self pay" patients. Medicare is a 100% federally funded and administered program whose hospital reimbursement rates are set directly by the federal government or its agents. Pursuant to PHL -2803(2), the Department is responsible for regulating rates and charges assessed by hospitals in regard to non-Medicare patients in accordance with methodologies authorized by PHL -2807-c.

5. The Medicaid program was established in 1965 pursuant to Title XIX of the Social Security Act, 42 U.S.C. -1396, *et seq*. It is a joint state and federal program to provide medical care to those who would otherwise be unable to afford such care. Under the terms of the Medicaid program, the federal government provides a percentage of the funding. In New York State, responsibility for the remaining monies is divided between the state and local governments. Pursuant to federal law, the Medicaid rate-setting methodologies employed by each state are subject to approval by the U.S. Department of Health and Human Services.

6. Blue Cross plans (of which there are several operating in New York) are not-for-profit health insurance corporations organized pursuant to Article 43 of the Insurance Law. They are closely regulated by the State and Blue Cross hospital rates have been subject to approval by the Department since 1966. Cost containment has been a primary factor in such rate approvals since at least 1969, when efficiency standards were incorporated into the rate setting criteria set forth in PHL -2807.

7. HMO's are organizations that provide or arrange for comprehensive health services to its members for a set, prepaid fee. They may be organized as either not-for-profit or for-profit entities. They are closely regulated pursuant to PHL Article 44.

8. Differentials in the cost of hospital services between Blue Cross plans and commercial carriers and self-insured groups have existed for many years in New York. Prior to 1988, commercial carriers and self-insured groups were deemed hospital "charge payors" and prior to 1978 hospital charges were not regulated. Between 1978 and 1982 only the rate of increase of such charges was regulated. Nonetheless, in the period prior to 1982 nearly all hospitals set hospital charges schedules at levels well in excess of their Blue Cross rate. Partly, this reflected Blue Cross plans prepayment and prompt payment policies, which benefited hospitals. It also reflected the fact that hospitals generally attempted to

make up any perceived shortfalls in their Medicare/Medicaid/Blue Cross revenue by increasing their charges.

9. In 1978 a decision was made to actively investigate the possibility of a major restructuring of hospital reimbursement in New York. One of the major participants in this investigation was a legislatively created commission, the Council on Health Care Financing, chaired by Senator Tarky Lombardi, Jr. This Council solicited information and recommendations from all interested parties, including the government, private insurers, the health care industry and the general public. In October of 1980 the Council issued a report entitled "Recommendations for Financing Hospital Inpatient Care." In his prefatory letter to Governor Carey, Senator Lombardi identified the Council's objective as "the establishment of a uniform mechanism for financing general hospital inpatient care, including methods of establishing equitable payments from all sources."

10. On pages 91-95 of its report the Council discussed "payment differentials among payors". It concluded that such differentials were "appropriate" as between cost-based (i.e., rate) payors and charge payors, but that "the current differential does not provide equitable payment from all sources". The Council noted that regional average differentials varied between 13% to 36%, with additional disparity stemming from payment rates negotiated by self-insured groups. The Council essentially recommended establishing a uniform differential, with limited exceptions for pre-existing reimbursement agreements between hospitals and self-insured groups. A copy of relevant portions of the Council's report is annexed hereto as Exhibit A.

11. By 1982 the average differential or surcharge paid by charge payors amounted to about 25% over and above the cost-based Blue Cross rates. This was the statewide average. In some areas of the state, however, the differential approached 40%. Some charge paying groups were able to use their group buying

power to negotiate lower rates with individual hospitals. However, while this was obviously to the advantage of those groups, it simply threw more of a burden on the remaining charge payors and/or had a negative impact on hospital financial stability.

12. Based in part on the Council's report, a new, comprehensive hospital reimbursement system was instituted in 1983. It was called New York's Prospective Hospital Reimbursement Methodology ("NYPHRM"). New York secured special permission from the federal government to set hospital *Medicare* rates for a three year period (1983-1985). In addition, relevant statutes and regulations were amended to more closely regulate hospital charges, including those covered by commercial carriers and self-insured groups. The overall goal of NYPHRM was to establish a coherent, integrated reimbursement system encompassing all classes of payors that provided adequate revenue to hospitals while promoting important social policy objectives (such as affordable health insurance) and efficiency in the provision of hospital services.

13. During the 1983-1985 period (generally referred to as "NYPHRM I") governmental inpatient hospital rates (including Medicare and Medicaid), Blue Cross rates and HMO rates were computed in accordance with methodologies which provided for uniform average *per diem* rates of payment for each day of hospital care rendered to eligible patients, regardless of the individual circumstances of each patient's care needs. Commercial health insurance carriers and self-insured groups continued to pay hospital charges, but hospitals were legally required to apply their inpatient charges uniformly to all charge payors at a level not to exceed 115% of their Blue Cross rates. This prohibited hospitals from negotiating "discount" charges with particular payor groups, while also preventing the hospitals from charging anyone more than 115% of their Blue Cross rate. The practical result was to enforce a generally uniform 15% differential between Blue Cross plans and charge payors.

14. A self-insured ERISA benefit plan challenged this new charge control system in federal court on the ground it was preempted by ERISA. It was argued that the charges controls "related to" ERISA because they prevented self-insured ERISA plans from negotiating discount charges with hospitals and thus forced the plans to spend more money for hospital services. However, the U.S. Court of Appeals for the Second Circuit ultimately ruled that hospital reimbursement regulatory provisions of this nature did not "relate to" ERISA and thus lay outside the scope of ERISA preemption. *Rebaldo v. Cuomo*, 749 F.2d 133 (1984).

15. The State Hospital Review and Planning Council ("State Council") is an independent body within the Department which consists of 31 persons appointed by the governor and confirmed by the Senate. See PHL -2904. The State Council's duties include adoption of hospital reimbursement rules and regulations. See PHL -2803(2)(a). In May of 1985 the State Council's Charge Differential Analysis Committee submitted a report to the full State Council. A copy of this report is annexed hereto as Exhibit B. This committee investigated the need and utility of the differential between Blue Cross and charge payors. It concluded that the Blue Cross plans' open enrollment/community-rated premium policies were "achieving a key social policy objective, and that some significant differential is necessary for Blue Cross to maintain its current mix of low risk/high risk subscribers" (see p. 7 of the report).

16. Commencing in 1986, the federal government resumed direct control of Medicare hospital rate-setting. However, for 1986 and 1987 the other aspects of the new reimbursement system, including the generally uniform differentials described above, were maintained in place. This 1986-87 period is generally referred to as NYPHRM II.

17. Commencing on January 1, 1988, a new hospital reimbursement system was instituted in New York in accordance with PHL -2807-c and 10 NYCRR 86-1.50 *et seq.* This new system (generally referred to as NYPHRM III) is based on a "case payment" methodology in which hospitals are paid a set price for each inpatient treated and discharged. These set prices are based on historical average adjusted reimbursable costs of inpatient care as adjusted for inflation and vary depending on the characteristics of the patient and the illness treated. Each price is designed to reflect the anticipated average cost for that hospital to efficiently treat a particular class or category of patient. Each patient discharged from the hospital is assigned to one of 794 diagnostic related groups ("DRGs"). In turn, each DRG is assigned a service intensity weight ("SIW") reflecting the anticipated relative average amount of hospital resources required to efficiently treat patients in that DRG. The reimbursement for a particular DRG reflects the SIW assigned to that DRG.[1] A discussion of the case payment system is included in a report submitted to the State legislature by the Department entitled Hospital Reimbursement Case Based Rates of Payment for 1988, 1989 and 1990. A copy of the report is annexed hereto as Exhibit C.

18. Each DRG rate is the sum of a number of different elements, including an "operating cost component", a capital cost component, a bad debt and charity care assessment, a trend factor adjustment to account for inflation between the base year and the rate year, a factor reflecting the hospital's medical malpractice costs, a factor reflecting the excess medical malpractice costs of physicians practicing at the hospital, and one or more of the

[1]It should be understood that the reimbursement for each DRG will vary from hospital to hospital. This reflects two major factors: (a) approximately 45% of the historical cost data used to compute a hospital's DRG rates is derived from that hospital's cost history, which is unique to that facility, and (b) the portion of each hospital's rates which reimburses for capital costs is separately computed and based on each hospital's individual capital costs, as approved by the Department.

differentials, if applicable. Some hospitals also receive additional adjustments, such as a primary health service program adjustment and/or a financially distressed hospital adjustment.

19. Under the new DRG case based reimbursement system, the differentials between Blue Cross plans and commercial carriers and self-insured groups was set at 13% (though these latter two payors were not, under the new system, called "charge payors"). In February of 1989, the State Council's Charge Differential Analysis Committee submitted another report to the full State Council. A copy of this report is annexed as Exhibit D. Again, the committee concluded (on p. 4 of its report) that:

> The differential has been, and should continue to be, used as a vehicle - although not the exclusive vehicle - to achieve a number of key social policy objectives aimed at assuring the availability of broad and affordable health insurance and a vehicle to provide necessary working capital for hospitals.

20. Commencing in 1991 certain methodological amendments not relevant to the instant lawsuit were instituted and the methodology from 1991 to the present is generally referred to as NYPHRM IV.

21. Under the current provisions of PHL -2807-c(1) there are three categories of payors for hospital inpatient services. The first class of payors consists of "governmental agencies" (i.e., Medicaid), "corporations organized . . . in accordance with article 43 of the insurance law" (i.e., Blue Cross plans), and "organizations operating in accordance with [PHL Article 44]" (i.e., HMOs). Hospitals bill patients covered by this category of payors (hereinafter "category A") at the DRG case payment per discharge amounts. See PHL -2807-c(1) (a).

22. The second category of payors (hereinafter "category B") consists of workers compensation, the volunteer firefighters benefit system, the "no-fault" motor vehicle insurance system, commercial health insurance carriers, and self-insured groups making direct payments to hospitals on behalf of beneficiaries. Hospitals are required to bill patients covered by these payors at 113% (reduced to 111% if payment is made promptly—see 2807-c(11)(e)) of the DRG case payment per discharge amount. Patients with commercial insurance coverage are assessed an additional 11% differential. See PHL -2807-c (1) (b).

23. The third category of payors (hereinafter "category C") essentially consists of all payors who do not fall into the first or second category. Included in this category would be "self pay" patients, patients covered by self-insured groups that do not make direct payments to hospitals, and patients covered by commercial insurance policies that do not pay on an expense incurred basis. Payors in this category pay hospital "charges" (i.e., prices) for the particular hospital services actually utilized by the patient. The sum of the charges billed to such payors may not exceed approximately 131% of the applicable DRG "price" that would otherwise apply to the patient in question.

24. The 13% differential (the "payment rate conversion factor") for category B payors dates from the inception of the DRG case payment system in 1988. The revenue generated by this differential is retained by the hospitals. The additional 11% adjustment factor (the "supplementary payment rate conversion factor" or "SPRCF") on the amounts hospitals are required to bill patients covered by commercial health insurance was added in 1992. See -348 of Chapter 55, Laws of 1992. (For all other category B payors the differential remained unchanged.) See PHL -2807-c(11) and 2807-c(14-e) .

25. The 11% SPRCF was added to the differential for commercial insurers because Blue Cross plans have experienced contin-

ued difficulty in retaining groups of low or average health risk subscribers in the face of the practices of commercial carriers, such as plaintiffs, which allow them to offer lower premiums to select groups with low health risks. This in turn has weakened Blue Cross plans economically and put at risk their continued ability to achieve the social objective of providing affordable health insurance to groups and individuals who might otherwise be unable to secure such coverage. Because of the State's own pressing fiscal needs, it was determined that the revenue generated by this 11% differential would be paid over by the hospitals to the State's general fund.

26. Pursuant to -346 of Chapter 55 of the Laws of 1992, PHL -2807-c was amended to provide for a contingent/variable differential of up to 9% to be added to the DRG rate billed by hospitals for non-Medicaid HMO patients. The revenue generated by this rate adjustment is paid over to the State's general fund. See PHL -2807-c(2-a) as further amended by Chapter 834 of the Laws of 1992. However, the statute also provides that this differential may be reduced or eliminated based on an HMO's enrollment of Medicaid patients. Elimination or reductions of the differential are also available if an HMO can demonstrate certain good faith efforts to expand its Medicaid enrollment. Of the thirty HMO's currently operating in New York, several have had their differentials eliminated or reduced in accordance with the criteria set forth in PHL -2807-c(2-a). It is the Department's hope and expectation that the continued operation of this law will result in substantially increased Medicaid enrollment in HMO's and in a concomitant increase in exemptions from the differential.

27. It is the State's policy to encourage the enrollment of Medicaid patients in HMO's because it is thought that the health care needs of Medicaid patients will be more effectively and efficiently addressed in a "managed care" setting. This policy is reflected, among other things, in the fact that HMO's are specifically prohibited from discriminating in enrollment on the basis of

"source of payment" (10 NYCRR 98.11(g)(7)). Thus, while one purpose of the differential on HMO rates is to generate revenue for the State, its ultimate and primary purpose is to encourage HMO's to enroll Medicaid patients.

PLAINTIFFS' CLAIMS

28. The gravamen of plaintiffs' contentions in this lawsuit is that the differentials are "related to" ERISA benefits plans (and are therefore preempted) because some ERISA plans have chosen to purchase commercial health insurance or HMO coverage from some of the plaintiffs and that said plaintiffs will be obliged to charge more for such coverage than they would if the differentials did not exist. Plaintiffs also claim to represent the interests of self-insured ERISA benefit plans who employ some of the plaintiffs as claims administrators and who chose to pay hospitals directly for services provided to their beneficiaries. Plaintiffs claim that the 13% differential "relates to" ERISA because, it is argued, in its absence, such self insured plans would pay less for hospital services for their beneficiaries. However, as set forth below, plaintiffs' arguments are not well founded.

29. The differentials are not legal obligations imposed on ERISA benefit plans. Rather, these differentials are simply part of a matrix of statutorily mandated State controls imposed on hospitals in New York. The challenged provisions of PHL -2807-c mandate what hospitals are legally required to charge various classes of payors. These provisions do not regulate the organization or benefit structure of ERISA benefit plans. Such plans are simply among the "vendees" in the marketplace for hospital services. Further, as such vendees ERISA plans currently purchase hospital services through all three of the above-described categories of payors under PHL -2807-c. Thus, some ERISA plans secure hospital coverage through Blue Cross or HMO's (category A payors). Other ERISA benefits plans secure commercial health insurance or are self-insured plans making direct

payments to hospitals (category B payors). Still other ERISA self-insured plans reimburse their individual beneficiaries, who pay hospitals according to their charge schedules (category C payors).

30. In addition to being free to select among payor mechanisms in all three payors categories under PHL -2807-c, ERISA benefit plans also remain free to structure their hospital benefits in accord with their resources and priorities. Nothing in -2807-c restricts their freedom in this regard. Thus, ERISA benefit plans may choose coverage that excludes some hospital services included in the DRG rate and responsibility for payment for those services devolves upon the patient. Such benefit plan coverage may also include deductibles, co-payment provisions, and/or maximum dollar amounts per day or per hospital stay, all of which require the individual patient/beneficiary to pay a portion of the hospital bill. Nothing in PHL -2807-c restricts the right of ERISA benefit plans to utilize some or all of these mechanisms to adjust the ultimate cost of their hospital services benefits. The key point here is that the nature and extent of benefits under ERISA plans are affected by many factors. The mere fact that State regulations of prices for hospital services may impact ERISA plans because such plans are one of many "vendees" in the market place for such services, cannot reasonably lead to the conclusion that the challenged differentials "relate to" ERISA.

31. Health care in general, and hospitals in particular, are subject to comprehensive state regulation in New York. In addition to regulating non-Medicare rates and charges, the State Hospital Code set forth detailed standards relating to hospital organization and operation. See 10 NYCRR Part 405. The Public Health Law further provides for state review and approval for the establishment, construction and/or expansion of hospitals in New York, for the deletion or addition of a hospital service or for major equipment purchases. See PHL -2801-a, 2802, 2803 and 2805. All of these state regulatory activities impact the cost and/

or availability of hospital services in New York-the same services which ERISA benefit plans seek to purchase on behalf of their members. Indeed in modern society, and especially in the area of health care delivery, state regulatory activity that affects the price of goods and services (whether directly or indirectly) is ubiquitous and cannot be avoided. Insulating ERISA benefit plans from such impacts is ultimately impossible and the attempt to do so will simply result in preemption that will be arbitrary and inconsistent.

CONCLUSION

32. The differentials under challenge in this lawsuit are key elements in New York's carefully structured and highly integrated hospital reimbursement system. They are firmly rooted in the State's statutorily mandated responsibility to regulate rates and charges for hospital services. Further, the 13% and 11% differentials reflect a long standing historical reality concerning the relationship between Blue Cross rates and prices paid by other payors. The mere fact that among vendees/consumers of these hospital services are patients covered by ERISA benefit plans or by FEHBA plans should not form the basis for eviscerating an essential State regulatory function relating to the health care system.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment and for a preliminary injunction should be denied and that defendant's cross-motions for summary judgment should be granted in all respects.

STEVEN C. ANDERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of James W. Clyne, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JAMES W. CLYNE, being duly sworn, deposes and says:

1. I am a Deputy Superintendent of Insurance and make this affidavit in opposition to the motions by plaintiffs in the above actions for summary judgment and in support of defendants' motions for summary judgment. I have been employed by the New York State Insurance Department ("Department") since 1961 and, prior to my appointment as a Deputy Superintendent in 1976, served as Chief of the Health & Life Policy Bureau ("Bureau") from 1974 to 1976. I am responsible for supervision of the Albany operations of the Department, including supervision of the Bureau, which reviews and, in accordance with the New York Insurance Law ("statute"), approves the policies and rates utilized by the plaintiff-insurers in New York State.

2. Employers in New York that provide, as an employee benefit, coverage for health care costs usually utilize one of three vehicles: a policy purchased from a commercial insurer licensed under either Articles 41 or 42 of the statute; a contract purchased from a health service corporation, such as the Blue Cross and Blue Shield plans, licensed under Article 43 of the statute or a health maintenance organization ("HMO") authorized under Article 44 of the N.Y. Public Health Law; or self-insurance. The

terms and conditions of the policies issued by commercial insurers and health service corporations have historically been subject to close regulation by the Department, *e.g.*, N.Y. Ins. Law §§ 3221 and 4305, respectively. HMOs are subject to the joint oversight of Departments of Health and Insurance. N.Y. Pub. Health Law §§ 4406, 4409. While the benefits provided under self-insured programs were never subject to regulation by the Department, it did, until the enactment of the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* (ERISA), regulate the financial condition of jointly administered employee welfare funds (former statute Article 3-A). At present, the Department's jurisdiction over such funds is restricted by ERISA to governmental and church plans which are not covered by ERISA and is exercised pursuant to Article 44 of the statute.

RELATION OF HOSPITAL RATE REGULATION AND INSURANCE REGULATION

3. While the benefits provided by employers are within the determination of the employer, except to the extent they are governed by collective bargaining agreements, many employers provide coverage for hospital care. The rates charged by hospitals in New York are subject to extensive regulation by the Health Department under Article 28 of the Public Health Law.

4. The Department also exercises authority over health service corporations and insurers who sell health insurance which has significant impact on health care. Pursuant to Article 43 of the statute, the Department approves the initial premium rates charged for community-rated contracts of health service corporations and premium rate increases for such contracts after a public hearing. In addition to premium rates, the Department approves all contracts between such corporations and their subscribers. N.Y. Ins. Law § 4308. The Department may, under § 4308, disapprove proposed premium rates which are "excessive, inadequate, or unfairly discriminatory." HMO rate setting is treated in

the same manner. N.Y. Pub. Health Law § 4406. The Department is also responsible for ensuring that Article 43 corporations maintain required statutory reserve funds for the benefit of their subscribers. N.Y. Ins. Law § 4310. Similar approval authority of health insurance contracts is given to the Department under Article 32 of the statute vis-a-vis commercial insurers. Thus, the Department must approve all health insurance policy forms prior to sale in New York State. N.Y. Ins. Law § 3201. With respect to premium rate-setting by commercial insurers, the Department reviews and approves either the rates themselves or the rating formula used by the insurer to set rates. N.Y. Ins. Law §§ 3201 and 4235. The Department may disapprove a health insurance policy form if the benefits provided therein are unreasonable in relation to the premium charged. N.Y. Ins. Law § 3201(c)(3).

5. Non-profit health service corporations, such as Blue Cross and Blue Shield plans (referred to herein collectively as "Blue Cross plans"), historically have provided open enrollment and other benefits to the public. This fact has been recognized for decades. A 1958 report commissioned by Governor Rockefeller, and prepared by Raymond Trussell of the Columbia University School of Public Health, traced the origins of non-profit health service corporations and noted that commercial insurers were originally "relatively or completely disinterested in selling hospitalization insurance." (Trussell Report, p.14, Exhibit "A" hereto). The report confirms that the purpose of the first non-profit health service plans was community-wide coverage for the general welfare of the public. Thus, generally speaking, these plans did not utilize experience rating (charging subscribers more or less depending on their utilization of benefits or chances of greater utilization of benefits) to set premium charges, thus providing affordable health insurance coverage on a broad scale. In exchange for these public services, these corporations have long been exempted from taxes, N.Y. Ins. Law § 4310(j), and the rates that hospitals charged them for hospital services provided to their subscribers has historically been lower than that charged by

hospitals to commercial insurance companies for services provided to their policyholders. *See* N.Y. Pub. Health Law § 2807-c(1)(b). The Trussell Report recognized that Blue Cross plans were traditionally given discounts by the hospitals.

6. In 1965, Governor Rockefeller appointed the Committee on Hospital Costs ("CHC") to study the problem of the increasing cost of hospital care and the resulting increases in Blue Cross rates which threatened the affordability of coverage for many. The Report concluded that the "higher cost of hospital care required a strengthening and extension of the sharing of risk," and thus, opposed, as being contrary to the interests of the community at large, any movement by Blue Cross plans to experience-rating, although it noted the pressure on Blue Cross to do so from competing commercial insurers that "do not practice community rating and are able to attract groups with favorable experience . . . ." (CHC Report, p.59, Exhibit "B" hereto). In sum, the differential historically reflected the Blue Cross plans contributions to important societal goals, availability and affordability of health insurance coverage.

7. In addition, as time went on, the differential reflected other beneficial Blue Cross practices, *e.g.*, pre-payment and prompt payment policies which gave hospitals financial stability. Because hospitals generally attempted to offset shortfalls in their Medicare/Medicaid/Blue Cross revenue by increasing their charges to commercial carriers, by 1982, the average differential paid by charge payors, which included commercial insurers, amounted to about 25% above Blue Cross rates, and in some regions was as high as 40%. Anderman Affid. ¶ 11. The differential has been codified in the Public Health Law since 1983, and has varied over time; the current differential provided for in Public Health Law § 2807-c(1)(b) is 13 percent and, in Public Health Law § 2807-c(11)(d), is 11 percent, for a total of 24 percent.

8. The differential has been a subject of constant study by the State and the Department has participated in these studies . In or about 1984, pursuant to former § 2803(2)(c) of the Public Health Law, the State Hospital Review and Planning Council ("SHRPC") studied the appropriateness of the differential. Given the Department's role in regulating Article 43 corporations and our concerns regarding the effect of any change in the differential on the availability of health insurance coverage, we examined the then-current system and reviewed underwriting practices of both non-profit and commercial insurers in order to decide whether and to what extent the differential should continue. A copy of the Department's submission to SHRPC in 1984 is annexed as Exhibit "C".

9. The Department found at that time that, under the then-current system, the Blue Cross plans were enrolling a substantial number of persons unable or least able to obtain health insurance coverage, and that the plans were able to do so because of the differential. (Exhibit "C", p.7). The commercial insurers that were surveyed by the Department (companies that wrote about 50% of the health insurance business in the state) either did not provide insurance to individuals or small groups or required evidence of insurability, added exclusions from coverage, or required additional premiums, because of the higher risks involved. The Department concluded that to continue the availability of health insurance coverage, "a hospital differential in favor of Blue Cross will have to continue" (Exhibit "C", p.7). If the differential were eliminated or reduced, the Blue Cross plans would not be in a position to make coverage available to those least able to obtain it and the government, through tax monies, would become the insurer of last resort through Medicaid or by subsidizing hospitals directly. The SHRPC agreed and concluded in its report that the differential should continue (Exhibit "D" hereto, p.3).

10. In 1988, the SHRPC, pursuant to legislative changes to the Public Health Law (L. 1988, ch.2), again requested the Department's input in its review of the appropriateness of the hospital differential. A copy of the Department's submission is annexed as Exhibit "E". At that time, we noted that, despite the increased availability of health insurance to individuals and small groups on a community-rated basis through open enrollment by the Blue Cross plans, the plans had actually experienced a reduction in the total number of subscribers covered by direct pay (individual and small group contracts) from 1983-1987. In addition, due to rising health care costs, substantial premium rate requests had been made by Blue Cross plans and HMOs over that period of time.

11. With respect to the availability of health insurance coverage, we also noted that commercial insurers and HMOs continued to not offer any health insurance contracts on an open enrollment basis, and commercial insurers offered health insurance to small groups only on the basis of strict medical underwriting which tended to result in the exclusion of substantial risks. These underwriting practices included requiring medical examinations, HIV tests and other tests, excluding entire groups if, *e.g.*, one employee was over the age of sixty or had more than $2,500 in claims in the prior year, and excluding entire occupations and industries from eligibility for coverage. The list of black-listed industries and occupations is long and has grown. It includes farming, fishing and logging, demolition work, messenger services, restaurants, parking lots, police and firefighters, window cleaners, florists, liquor stores, orchestras, actors, barber shops and beauty shops, blood banks, hotels, motels, taxi drivers and truckers.

12. With regard to open enrollment, data provided to the Department from the Blue Cross plans indicated that, in 1983, Blue Cross plans had a total direct pay subscriber enrollment of 752,834. That number decreased by 144,862 to 607,972 by 1987. As for small groups, in 1983, Blue Cross plans had 2,055,150

subscribers enrolled; in 1987, that number had fallen to 1,855,596 (Exhibit "E", p.3).

13. Based upon these findings, the Department adhered to its view that a hospital differential is needed to ensure that Blue Cross continues to enroll those unable or least able to afford coverage and it must be sufficient to keep the Blue Cross plans from changing their underwriting standards and moving towards experience rating to exclude higher risks. The SHRPC report agreed and recommended continuation of the differential (Exhibit "F", p.6).

14. Chapter 2 of Laws of 1988 established the differential at 13 percent, but also included provisions allowing for its reduction to 11 percent for any commercial insurer which offered continuous open enrollment. The Department was required to evaluate insurers performance under this new provision, to establish standards and criteria for determining whether any insurers were entitled to the reduction, and to report our findings and conclusions. Laws 1988, ch.2, § 335. On March 8, 1989, the Department promulgated Regulation No. 137, 11 NYCRR 42, which set forth open enrollment requirements for health insurers to qualify for the reduction. The Department issued two reports pursuant to this provision, one in December, 1989, and the other in October, 1990, in which we reported that no commercial insurers had taken advantage of the opportunity to qualify for a reduction in the 13 percent factor.

15. As time has gone on, the proportion of claims paid by Blue Cross plans which involve payment for in-patient hospital stays subject to the rate mechanism of the Public Health Law has decreased relative to the total of health care costs. In addition, the commercial insurers have continued to siphon off the best risk from Blue Cross' community-rated pools. Between 1987 and 1989, for example, Empire Blue Cross, the largest New York health services corporation, lost 110,000 direct pay subscribers and 440,000 group subscribers. Thus, the utility of the 13 percent differential in providing a "level playing field" to these corpora-

tions in their competition with commercial insurers which can selectively underwrite their risks has diminished. This has resulted in a competitive disadvantage of these not-for-profit corporations and an inability to maintain a mix of high, low and average risks.

16. In August, 1991, Empire Blue Cross applied for a rate increase and indicated its intention to begin to selectively underwrite some risks as of October 1, 1991. After an extensive public hearing in September, 1991, the Superintendent of Insurance deferred action on Empire's request and called upon the Legislature to take action to assist these corporations in competing with commercial insurers. A copy of the Superintendent's letter to Empire Blue Cross is annexed as Exhibit "G". The Superintendent recognized that Empire was faced with a decreasing statutory surplus and mounting underwriting losses, despite an average rate increase of 18.9% granted in early 1991, and that "more and more small groups with favorable claim experience are departing from Empire leaving a smaller and sicker" community pool (Exhibit "G", p.2). These difficulties result primarily from the fact that commercial insurers choose to insure only the healthiest customers, thereby keeping their premium rates down, and leaving Blue Cross plans with the poorest risks. However, the Superintendent concluded that he could not allow Empire to split its small group community-rated pool or to increase individual subscriber rates by as much as requested, up to 50 percent. He called upon the Legislature to enact legislation to address the problem of access to affordable health insurance.[1]

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[1]In legislative hearings held in 1991 and 1992 testimony addressed the need for additional help for Blue Cross. Representatives of the commercial insurers recognized that the 13 percent differential was intended to level the playing field for Blue Cross, but insisted that the 13 percent plus the Blue Cross tax exemption was sufficient to do that; no more help was needed. (Testimony of plaintiff HIAA before Senate Insurance Committee, Testimony of plaintiff LICONY before Assembly Small Business and Insurance Committees, Exh. "H").

17. On April 1, 1992, the Superintendent granted Empire a rate increase. A copy of the Opinion and Decision is annexed hereto as Exhibit "I". The Superintendent noted that, in 1991, Empire had experienced an underwriting loss of $174 million on its community-rated business with a net loss of $150 million. Without a rate modification, projections showed that Empire's reserves would fall below zero by mid-1992. One of the factors found by the Superintendent to contribute to the 1991 community-rated underwriting loss was the continuing decline in enrollment of small groups of under 50 persons. The number of small group contracts declined from 457,850 at December 31, 1990 to 373,691 at December 31, 1991. That loss, together with 1989 and 1990 losses of 131,529, significantly reduced the community-rated pool.

18. The Department's analysis of Empire and other non-profit health insurers demonstrates that if community-rated pools continue to lose enrollment and the rates continue to increase, the end result will be the unavailability and unaffordability of health insurance coverage causing many New Yorkers to be without health insurance protection and without a method of financing health care benefits. The Superintendent again, in his decision on Empire's rate request, called upon the Legislature to enact the Governor's proposed legislation. That proposal, as it related to community-rating and open enrollment, was enacted this year (Laws 1992, ch.501). Meanwhile, the increase to the commercial insurers' hospital reimbursement rate became part of the State's budget negotiations and it was enacted as part of the Omnibus Tax Revenue Act (Laws 1992, ch.55, § 348). Under that provision, the differential for commercial insurers *only* is increased by an 11 percent supplementary payment conversion factor for a one year period from April 1, 1992 to March 31, 1993, the State's fiscal year. These amounts are required to be deposited in the State's general fund.

19. The link between the differentials and the regulation of insurance marketplace has been demonstrated. Commercial insurers and HMOs have declined to accept individuals and small

groups for health insurance coverage on an open enrollment basis, and commercial carriers have generally experience-rated small businesses. Blue Cross plans, on the other hand, offer open enrollment to all individuals and small groups on a community-rated basis. Thus, poorer risks are forced to obtain coverage from Blue Cross plans which allows the commercial insurers to offer more competitive rates to the better risks which, in turn, depletes the number of better risks insured by Blue Cross. This, of course, has raised the costs of Blue Cross plans and forced them to request substantial rate increases. As a result, both individual and small groups have been dropping coverage, with the better risks moving to commercial insurers who offer lower premiums. This cycle, resulting in dwindling community pools and higher costs for Blue Cross subscribers, is partially offset through the application of the differentials which restore some measure of equality to the insurance marketplace by giving Blue Cross a competitive advantage which enables them to attract good risk customers seeking lower payments to hospitals. Were it not for the differentials, the inability to attract good risk customers would result in a smaller and smaller risk pool, comprised of predominantly poorer risks causing higher premium rates and the deterioration of a viable health insurance system. As such, both the 13 percent and the 11 percent differentials are exercises of New York's long-standing authority to regulate insurance.

DEPARTMENT'S REGULATION OF STOP-LOSS INSURANCE POLICIES

20. Beginning in the 1970's (and in more limited fashion in the 1960's) some employers that had opted to fully insure their employee benefits turned to various new insurance products to minimize their costs, especially the cost of premium taxes, and subsequently to avoid mandated benefit laws. An employer may enter into administrative services only ("ASO") contract with a third party administrators ("TPA"), including insurers, whereby the claims are determined by the TPA and paid on behalf of the employer by the administrator utilizing funds provided by the employer. Such employer may also purchase excess risk insur-

ance, also known as stop-loss coverage, whereby an insurer will pay losses above a specified amount. Usually a commercial insurer enters into both ASO and stop-loss contracts with an employer. Plaintiff Travelers Insurance Company ("Travelers") has done this with the Sheridan Catheter Corporation ("Sheridan") whose ASO and stop-loss contract is annexed as Exhibits "B" and "C" to the affidavit of James Gutterman submitted with Travelers' motion papers.

21. Stop-loss contracts usually provide that the insurer will reimburse the employer if claims exceed a specified amount within a period of time, either on a per claims basis or in the aggregate. Usually, the insurer has no direct obligation to the employee and is merely obligated to pay claims on behalf of the employer under the ASO contract and reimburse the employer under the stop-loss contract. Sheridan's stop-loss contract has both an individual and aggregate threshold amount. If the benefits paid by Sheridan during the contract period for any one employee or dependent exceed $90,000, Travelers provides coverage. According to the Gutterman affidavit (although this is not apparent from the stop-loss contract itself), if the aggregate benefits paid by Sheridan during the contract period exceed 125% of anticipated health care claims, Travelers must provide coverage.

22. The Department has consistently taken the position that stop-loss contracts which reimburse an employer for medical and hospitalization expenses of its employees above certain amounts, while not a traditional type of insurance contract, are subject to the same requirements of law as are applicable to other accident and health insurance contracts providing hospital and medical coverage. The reasons the Department took this position are several. First, our analysis of the excess risk policies we reviewed showed that they provided benefits for expenses incurred due to sickness and disease. Such benefits are within the type of benefits covered by insurance contracts authorized by N.Y. Insurance Law § 1113(3) which covers accident and health insurance. In addi-

tion, the Department was concerned that employees may not realize that their employer has not purchased a traditional health insurance policy and may not understand the benefit coverage provided by the employer and the coverage provided by the excess risk insurer. Furthermore, the Department had other specific concerns about the sale of stop-loss policies: one, the Department was concerned the employees would not be provided with continuation of benefits due to financial impairment of the underlying employer plan. The Department determined that the excess risk insurer must be responsible for run-off claims and have sufficient reserves set aside to cover these risks. Finally, the Department was concerned that excess risk insurers not assist or acquiesce in any misrepresentation of benefits provided by the employer. The Department's Actuarial Information Letter 5, issued originally on June 27, 1985, was prompted by some of these concerns. The Letter sets forth the minimum requirements for the Department's approval of stop-loss policies. These requirements are directed solely at the insurer. The current version of the Letter is annexed as Exhibit "J".

23. An analysis of the Letter establishes that it constitutes a regulation of the insurer. Item 1 of the Actuarial Letter, dealing with mandated benefits and conversion policies respectively, are not intended to affect the provisions of an employer's plan subject to ERISA. The Department does not review the underlying ERISA plans and does not require changes in plans. The Letter requires only that the stop-loss insurer ensure that such benefits are covered and we accept the insurer's representation. The Department does not enforce this item against self-insured plans; its only recourse is to refuse to approve the stop-loss policy form. Item 2 requires the insurer to either provide conversion policy to an individual terminating coverage under the employers' plan in accordance with N.Y. Ins. Law § 3221(e) or by contracting with another insurer to do so. Again, this requirement is directed solely at the stop-loss insurer and has little or no impact on the underlying employer plan.

24. It is possible that the ASO or stop-loss contracts will provide that the insurer is obligated to continue to make payments for treatment incurred after the employer's plan terminates. These are usually referred to as runoff claims. Item 3 of the Actuarial Letter, dealing with notice of an insurer's obligation for runoff claims, requires that the insurer give notice to covered employees of the extent of insurer's obligation for runoff claims. Item 4 of the Actuarial Letter, dealing with responsibility for reserves for runoff claims, is intimately connected to the Department's authority over the financial condition of insurers. Item 5 of the Actuarial Letter, dealing with responsibility for runoff claims, reaches only the insurer, requiring it to assume responsibility for those claims unless replaced by another insurer, and imposes no obligation on an ERISA plan.

25. Item 6 of the Actuarial Letter, dealing with those groups that may be issued stop-loss contracts, is also directed only to the excess risk insurers and is consistent with the minimum participation requirements and eligibility requirements imposed on certain groups recognized in Insurance Law § 4235. Item 7 of the Actuarial Letter simply requires a rate filing by the stop-loss insurer. It is designed to ensure the financial stability of insurers and is part of New York's comprehensive regulation of insurance rates.

26. To the best of my knowledge, we have never received a complaint from either an employer or a self-insured plan administrator that the Actuarial Letter has prevented any insurer from issuing or any plan from purchasing stop-loss coverage.

27. Accordingly, the motions of plaintiffs should be denied and that of defendants granted.

JAMES W. CLYNE

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IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Stuart L. Lefkowich, filed October 2, 1992

[HIAA v. Chassin]

* * *

STUART L. LEFKOWICH, being duly sworn, deposes and says:

1. I am employed by the New York State Department of Social Services (Department) in the position of Assistant Commissioner. I serve as Director of the Bureau of Primary Care, Division of Medical Assistance. I am responsible for policy implementation relating to health maintenance organizations (HMO's) and managed care in the Medical Assistance (Medicaid) Program, established pursuant to Title 11 of Article 5 of the Social Services Law (SSL), Chapter 55 of the Consolidated Laws of New York.

2. I make this affidavit in opposition to Plaintiffs' motion for summary judgment and in support of Defendants' cross-motion for summary judgment.

3. The Medicaid Program is a joint federal-state assistance program for needy persons who cannot afford the expense of medical care. Title XIX of the Social Security Act (Act), 42 U.S.C. 1396 *et. seq.*, authorizes federal financial participation in the cost of furnishing medical care and services to eligible persons in accordance with a State Plan submitted by the state Medicaid agency and approved by the Secretary of the federal

Department of Health and Human Services as complying with Section 1902 of the Act, 42 U.S.C. 1396a.

4. The Department is designated as the Medicaid single State agency responsible for submission of a Medicaid State Plan to the Secretary of Health and Human Services and supervision of administration of the Medicaid Program in New York State (SSL 363-a).

5. Section 1903(m) of the Act, 42 U.S.C. 1396b(m), provides for federal financial participation, subject to stated conditions, in expenditures for Medicaid services furnished by HMO's. Section 365-a(2)(k) of the SSL authorizes Medicaid payment for comprehensive services furnished by HMO's "when such services are furnished in accordance with an agreement approved by the Department which meets the requirements of federal law and regulations."

6. Section 1915(b) of the Act, 42 U.S.C. 1396n(b), authorizes the Secretary of Health and Human Services to waive requirements of Section 1902 of the Act as necessary to permit a state "to implement a primary care case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain medical care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary . . ." Section 364-j of the SSL directs the establishment of managed care programs under which "[Medicaid] recipients receive [Medicaid] services directly and indirectly (including by referral) from a managed care provider, *including case management* . . ." (emphasis added).

7. Legislative enactments show an increasing emphasis by the New York State Legislature on inclusion of case management in Medicaid services delivery, both by HMO's and other provider

entities. In Chapter 904 of the 1984 Laws of New York, the Legislature declared: "It is the intent of the legislature to explore new approaches to the delivery of health services to beneficiaries of the medical assistance program that will assure quality medical care and that will improve the continuity and comprehensiveness of health services. Further, it is the intent of the legislature to broaden health care options for these beneficiaries to include primary physician case managers, conventional health maintenance organizations and new special purpose comprehensive health services plans as alternatives that can be voluntarily selected by beneficiaries."

8. In Chapter 710 of the 1988 Laws of New York, the Legislature added Section 364-j of the SSL to establish managed medical care demonstration programs. The State Commissioner of Social Services was authorized and directed to apply for any appropriate federal waivers. Managed care providers could include physicians, county health departments, providers of comprehensive health services plans (HMO's) licensed pursuant to Article 44 of the Public Health Law, Chapter 45 of the Consolidated Laws of New York, and hospitals and diagnostic and treatment centers. Primary responsibilities of the managed care provider included "management of the medical and health care needs of participants" and "referral, coordination, monitoring and follow-up . . ."

9. In Chapter 165 of the 1991 Laws of New York, the Legislature amended Section 364-j of the SSL to convert managed care from a permissive, demonstration concept to a mandatory program of general applicability throughout the State. The State Commissioner of Social Services was directed to prepare a State managed care plan providing for the implementation of managed care programs in social services districts and to designate, in succeeding years, approximately one-third of the social services districts in the State to develop managed care programs. After three years of managed care program implementation, only those

social services districts given specific exemptions would not have managed care programs. Social services districts implementing managed care programs would be required to establish incremental enrollment goals culminating in participation by 50% of the non-exempt Medicaid population within five years.

10. The legislative evolution of managed care in New York State has made case management of greater importance in the delivery of Medicaid services. Since the legislative declaration of 1984, HMO's have been the primary source of case managed care to Medicaid recipients in New York State. In 1992 to date, there are 23 HMO's offering Medicaid services. The other sources of Medicaid case managed care are 7 physician case management programs and 7 other non-HMO programs.

11. In April 1992, the New York State Legislature enacted subdivision 2-a of Section 2807-c of the Public Health Law, which was added in identical form by Section 95 of Chapter 41 of the 1992 Laws of New York, effective April 2, 1992 and Section 346 of Chapter 55 of the 1992 Laws of New York, effective April 10, 1992. In August 1992, subdivision 2-a was amended by Chapters 834 and 843 of the 1992 Laws of New York. Subdivision 2-a imposes a 9% factor, payable to a statewide HMO pool created by the State Commissioner of Health and credited to the State General Fund, upon rates of payment to general hospitals for reimbursement of inpatient hospital services furnished to subscribers of HMO's, excluding Medicaid eligibles and regional pilot project participants, and provides for an exemption from participation by an HMO in a social services district's Medicaid managed care program.

12. Subdivision 2-a acts as an incentive to HMO's to participate as managed care providers in the Medicaid Program, providing for an incremental reduction of the 9% factor by 25%, 50% and 75% if an HMO becomes a Medicaid managed care provider and enrolls like percentages of a target number of Medicaid

eligible persons and for elimination of the 9% factor if an HMO becomes a Medicaid managed care provider and enrolls at least 90% of a target number of Medicaid eligible persons. A significant increase in HMO Medicaid participation in 1992 is reflected by the number of HMO's with Medicaid contracts in the indicated years: 1988-2; 1989-5; 1990-9; 1991-13; 1992-23. Plaintiff Aetna Health Plans of New York, Inc. entered into a Medicaid contract with the New York City Human Resources Administration effective April 15, 1992 but has not enrolled a sufficient number of Medicaid eligible persons to qualify for reduction or elimination of the 9% factor.

13. The Legislature also provided in subdivision 2-a for an exemption mechanism relating to an HMO's failure to become a Medicaid managed care provider in a social services district by not entering into a managed care contract with such district. Subdivision 2-a states that an HMO "may apply to the state commissioner of social services on or before May first for the nineteen hundred ninety-two rate period . . . for an exemption from participation in managed care programs in a social services district on such bases as demonstration of a good faith effort to enter into a managed care contract with the social services district . . ." (Pub. H.L. § 2807-c(2-a) (b) (iii)). The effect of an exemption of an HMO from participation as a provider in a social services district's managed care program is that the HMO's service area is deemed not to include such social services district. Accordingly, no target number of Medicaid eligibles is calculated for that social services district. If an HMO receives exemptions from participation as a managed care provider in all social services districts in its service area, then the 9% factor to be imposed upon inpatient hospital service payments made by the HMO to general hospitals would be eliminated for the applicable rate period.

14. For the 1992 rate period, 21 HMO's have applied for exemption from participation in a social services district's man-

aged care program. Of those applications for exemption, seven have been granted, eleven denied, two granted in part and one is pending determination. Plaintiff Aetna Health Plans of New York, Inc. did not apply for exemption from participation for the 1992 rate period.

15. As a result of the granting of exemptions or enrollment of numbers of Medicaid eligible persons meeting target number percentages, eight HMO's qualified for elimination of the 9% factor for the 1992 rate period and two HMO's qualified for reduction of the 9% factor for the 1992 rate period.

16. Case managed care, authorized under the federal Social Security Act and delivered by HMO's as managed care providers, is becoming a primary element in the evolution of the New York State Medicaid Program as a source of high-quality, cost-effective care for needy persons and the 9% factor serves as an incentive to HMO's to participate in serving the Medicaid population.

By reason of the foregoing, the Plaintiffs' motion for summary judgment should be denied in its entirety and the Defendants' cross-motion for summary judgment granted.

STUART L. LEFKOWICH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Arthur B. Klein, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ARTHUR B. KLEIN, being duly sworn, deposes and says:

1. I am the Vice President of Provider Audit and Reimbursement for Empire Blue Cross and Blue Shield. As such, I am fully familiar with present and past hospital reimbursement schemes in the State of New York. I make this Affidavit in support of the New York State Conference of Blue Cross and Blue Shield Plans' and Empire's Cross Motions for Sumary Judgment in these actions.

2. The differentials here at issue are part of New York State's regulation of hospitals' costs, charges and reimbursement. The purpose of this Affidavit is to set forth some background as to the hospital reimbursement and rate setting scheme in New York.

3. New York's comprehensive regulation of hospital care, hospitals costs and reimbursement, and health insurance reflects its long-term commitment to hospital cost containment. That commitment is part of the State's responsibility to see that its citizens can afford the health care and insurance they need as well as provide aggregate financing to assure the viability of the hospital system.

4. The magnitude of the hospital system in New York is astounding. There are approximately 280 acute care, general hospitals in New York State. In 1991, the total revenues paid to those hospitals was approximately 20 billion dollars. Approximately $6 billion was attributable to the Federal government's Medicare program, with the remaining $14 billion subject to New York's hospital cost control law.

5. Pursuant to Public Health Law §2803(2)(a)(ii), the Commissioner is given the authority to approve rules and regulations adopted by the State Hospital Review and Planning Council establishing "schedules of rates, payments, reimbursements, grants and other charges for hospital and hospital related services . . . provided in twenty-eight hundred seven - c [the DRG legislation] of this Article."

6. Pursuant to Public Health Law §2807(2), payments to hospitals for inpatient services by the Plans, HMOs, the Medicaid program and other payors (except Medicare) must be at rates approved by the Commissioner. The Federal government's Medicare program has its own rate setting statutes and all references in this Affidavit to rates or payors exclude Medicare.

7. Prior to approval of such rates, pursuant to Public Health Law §2807-c(2)(b), the Commissioner must determine that the proposed rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

HISTORY OF HOSPITAL REIMBURSEMENT

8. Prior to 1970, hospitals were reimbursed on a retrospective, reasonable-cost basis. A hospital was reimbursed, within very general limits, for the actual cost of whatever care it rendered. Such retrospectively determined reimbursement did not provide motivation for hospitals to control their costs.

9. The rate of inflation in hospital costs quickly reached an unacceptable level, threatening to put adequate health care beyond the reach of many citizens of the State. The rising cost of hospital care threatened the public purse which financed the State's Medicaid program, as well as the millions of New Yorkers covered by Blue Cross health insurance.

10. In the face of the crisis caused by the spiraling inflation in hospital costs, the Legislature enacted the Hospital Cost Control Law of 1969. The new law applied to state and local government payments for the Medicaid program, as well as Blue Cross hospital insurance. The purpose of the law was clear from the legislative findings and purpose:

> Rising hospital costs are a matter of vital concern to the people of this state. The alarming increases in such costs encountered in recent years pose dangers to all purchasers of hospital services as well as hospitals themselves.
>
> * * *
>
> The legislature therefore finds and declares that *it is essential that an effective cost control program be established which will both enable and motivate hospitals to control their spiraling costs.* It is the intent of this chapter to provide for uniform measures on a state-wide basis to control hospital costs without the sacrifice of quality of service. (Chapter 957, 1969 N.Y. Laws) (Emphasis added)

11. To achieve this goal, the Hospital Cost Control Law amended §2807 of the Public Health Law. The new law obliged the Commissioner to develop "an effective cost control program" which would "enable and motivate hospitals to control their spiraling costs," and directed the Commissioner to certify

only those payment rates to hospitals that are "reasonably related to the costs of efficient production of hospital services".

12. The Commissioner therefore developed regulations to establish a system of "prospective" reimbursement. Under prospective reimbursement, a payment rate is established for each hospital in advance of the rate year in order to give each hospital an opportunity to plan its budget accordingly. If, during the rate year, the hospital's cost of providing care is less than the payment rate, the hospital retains the difference. If the cost of care is greater than the payment rate, the hospital absorbs the difference. Thus, prospective reimbursement encourages the hospitals to make their own operations more efficient.

13. This system of prospective reimbursement, in which the Commissioner of Health, the Superintendent of Insurance, and Blue Cross have worked closely with the hospitals to help control their costs, has transformed New York from a state with one of the fastest growing rates of inflation in hospital costs to one with a rate of increase that consistently has been below the national average.

14. Over time the methods of reimbursement were refined and more sophisticated methods of determining hospital rates were developed. For example, rates were limited to the average cost of similar hospitals, even though the hospital in question may have spent considerably more. These reimbursement provisions were repeatedly challenged in court by hospitals, but were invariably upheld. *See Brooklyn Hospital v. Axelrod,* 97 A.D.2d 493 (2d Dept. 1983), *aff'd* 61 N.Y.2d 1012 (1984); *Jewish Memorial Hospital v. Whalen,* 47 N.Y.2d 331 (1979).

15. Many of the significant changes in hospital reimbursement methods coincided with the fiscal crises of New York City during the mid-1970s (since the City pays a large portion of Medicaid costs) and the fiscal crisis of New York State itself in the late

1980's. Throughout both the 1970's and the 1980's the cost of hospital care was a recurrent theme at the public hearings which the Superintendent of Insurance is required to hold prior to approving applications by Blue Cross and Blue Shield to increase premium rates (*See* N.Y. Insurance Law §4308).

16. By the late 1970's New York was rigorously regulating the hospital rates paid by the State Medicaid program, Blue Cross and Blue Shield and health maintenance organizations (HMOs). Other payors (such as workers' compensation, no-fault auto insurers, commercial insurers and self-insured plans) were paying hospital charges (which were limited to some extent by legislation) and sought to have the cost control laws to apply to them as well. On the other hand, hospitals argued that if all hospital rates were regulated without any margins for discretionary use of funds to cover the hospitals costs of caring for persons without health insurance, the hospitals would be placed in dire financial straits.

17. The Legislature adopted new legislation which attempted to meet both goals. Beginning in 1983, hospital rates became more regulated for all categories of payors, and by 1988 all payors received the benefit of the State's hospital cost control legislation. However, a factor was added to every hospital bill (now averaging approximately 5% for hospitals statewide) to compensate hospitals for bad debts and charity care incurred when rendering care to patients who had no health insurance and could not pay for that care out of their own pocket. The new legislation was referred to as NYPHRM—New York Prospective Hospital Reimbursement Methodology.

BACKGROUND OF PRESENT REIMBURSEMENT UNDER NYPHRM

18. Presently, the reimbursement rates for inpatient hospital care are established pursuant to §2807-c of the Public Health Law.

19. Under the NYPHRM system, inpatient rates are generally based on each hospital's costs expended during 1981, which is referred to as the base year. In each subsequent rate year, the fixed base year costs for 1981 are increased by up to three additional factors which are described below. *See* Public Health L. §2807-c(l)(d) and Regulation 86-1.50(e).

20. Each year the base year costs are increased by an inflation factor (called a trend factor), which is determined by a panel of economists. *See* Public Health Law §2807-c(10).

21. In some years, the base year costs may also be increased by appeals submitted by the hospitals. *See* Public Health Law §2807-c(9). Appeals are generally granted for services which the hospital has just begun to provide and therefore are not encompassed in the hospital's 1981 base year costs, or may be granted for unusual costs which are beyond the hospital's control, such as nursing salary increases which far exceed the trend factors.

22. In some years the Legislature decides that a fixed dollar amount should be added to the 1981 cost base of all hospitals located in the State. This occurred in 1988 and 1991. These additional statutory amounts added to the hospitals' fixed 1981 base year costs are referred to as enhancements. A methodology is prescribed to allocate the total value of the enhancements among the cost base of the various hospitals in New York State. *See* Public Health Law §2807-c(1)(e).

23. In summary, under the NYPHRM system, hospital inpatient rates are based upon the hospitals 1981 base year costs, plus trend factors for each year from 1982 to 1991, plus any appeals approved by the Commissioner, plus statutory enhancements to the cost base.

24. Until 1987, hospital inpatient rates were established on a per day basis. If a patient remained in the hospital for five days, the hospital was paid five times the per day rate.

25. Beginning in 1988, most rates were established on a per case basis. The hospital is paid a fixed amount for each patient stay, regardless of how long that patient remains in the hospital. That fixed amount per patient is adjusted due to the intensity of patient care, which is measured by the diagnosis which applies to that patient, according to a classification system known as Diagnosis Related Groups, or DRGs. *See* Public Health Law §2807-c(3). The rate is decreased for diagnosis reflecting low intensity of patient care or increased for diagnosis reflecting high intensity patient care.

The Eight Components Of The Rate

26. The typical hospital rates established under the current Public Health Law have eight distinct components: operating costs (for room and board, nursing, dietary, etc.), capital costs, the hospitals own malpractice insurance, bad debt and charity care, primary health service program, financially distressed hospitals' program, excess malpractice insurance paid for by the hospital for its physicians and a 13% additional portion (the differential). As of April 1, 1992, the additional portion for commercial insurers is 24%, rather than 13%. Each of these components is separately identified on rate sheets which the Department distributes to hospitals. Copies are provided to the various payors as well.

27. Each of these rate components, except for the differential, vary from year to year and therefore contribute to the amount paid by an insurer or payor to reimburse hospitals for rendering services.

28. The largest portion of the rate is for operating costs, such as room and board, nursing services, dietary department, etc. The operating cost component is an average amount which represents the average cost of treating a patient. Since it is an average, by definition a hospital spends more on some patients and less on others. As an incentive for hospitals to control their costs, the rate is based upon a variety of methods which limit reimbursement to the cost incurred by an average hospital. Hospitals that have costs higher than the average have a strong incentive to reduce costs since their reimbursement will be based upon an average rate that is less than their current costs. If a hospital's costs are less than the average reflected in the rate, the hospital is permitted to keep the difference, and that adds to the incentive to limit costs and the ability to provide better patient care.

29. In a complex rate setting system with these types of incentives to control hospital costs, it is almost impossible to identify the total cost of treating any one patient. Therefore, the Plaintiffs' statements that the rate setting system causes Plaintiffs to pay more than it costs hospitals to provide services to patients covered by the Plaintiffs is meaningless.

30. Within statutory parameters, the State increases hospital rates which costs the Plans and all payors more than if that adjustment had not been made.

31. For example, each year the component of the hospital's rate for operating costs is increased by a trend factor established by a panel of economists which is designed to account for inflationary trends (*See* Public Health Law §2807-c(10).) Obviously, hospital rates paid by insurers and self-insured plans would be lower if this trend factor was not applied to increase the rates each year.

32. Another example relates to rate adjustments based on quality of care factors. In 1989 the Commissioner of Health adopted new regulations that limited the number of hours which interns

and residents could work and required experienced physicians to be at the hospital to supervise the physicians in training (*See* 10 NYCRR Part 405). Since these changes in hospital staffing imposed additional costs on the hospitals, the Commissioner (pursuant to Public Health Law §2807-c(l)(f)) ordered that hospital rates be increased to reflect the additional costs. The total annual cost of the Part 405 adjustments for the first year of the new system was approximately $122 million.

33. A third example is the hospitals' capital costs. The Public Health Law requires that hospitals obtain the Commissioner of Health's prior approval of the scope and cost of capital construction. *See* Public Health Law §2802. The reimbursement provisions provide that the approved capital costs be included in the hospitals rate. *See* Public Health Law §2807-c (8). The result is that each time a hospital constructs a new wing, or undertakes extensive renovations, the commissioner's approval must be obtained and the additional capital costs are then added to the hospital's rate. This ultimately increases payments by all payors.

34. These examples demonstrate two important points: first, the State's hospital cost control efforts are intricately intertwined with its efforts to regulate the quality and availability of hospital care and to assure sufficient aggregate financing to maintain the viability of the hospitals. Regulations designed to improve the quality of care and the capital facilities utilized by hospitals are contingent upon methods to finance those improvements. If a State is not free to increase hospital rates in order to finance improvements in quality of care and capital facilities, then the State's ability to regulate the quality and availability of care is dramatically reduced.

35. Secondly, New York State has undertaken to regulate and limit hospital charges and that effort has been extremely successful; reimbursement to hospitals in New York has risen at a far more limited pace than in other states. There is no doubt that

payments to hospitals by the Plaintiffs are far less under the State's rate regulation scheme than if the hospitals were allowed to charge whatever amounts the hospitals decided to charge. That overall purpose (and indeed success) should not be obscured by Plaintiffs' focus on one small portion of the rate setting process.

36. In summary, the Plaintiffs have benefited enormously from the State's cost control effort. Plaintiffs would likely have paid literally millions of dollars more to hospitals in the absence of the State's cost control statutes and rate setting process. It is also important to note that the patients covered by the Plaintiffs have benefited from the readily available hospital care offered in New York State and the quality and technology offered by the hospitals in New York. The State's regulatory initiatives and oversight of hospitals, including the reimbursement system, are partly responsible for those benefits.

37. It is a truism to allege (as the Plaintiffs do) that inclusion of any particular component of the total rate costs insurers and payors more than if that component had not been included at all. Unless the Plaintiffs expect free care from hospitals, any rate setting by the State will cost insurers and payors more than if there was no rate at all or if the rate was lower. The real issue is whether a State has the regulatory authority to impose an overall cost control scheme in lieu of an unregulated market where the hospitals charge what they choose. If a State has authority to limit what hospitals charge to ensure a viable system of financing hospital care, then by practical necessity the State must have the authority to decide what the components of that rate setting process will be.

Payor Categories And The Differential

38. The current provisions of the Public Health Law identify or contemplate thirteen different types of payors that reimburse

hospitals. The statute classifies them into three different categories. *See* Public Health Law §2807-c(1)(a), (b) and (c).

39. The first category includes: Blue Cross and Blue Shield Plans, health maintenance organizations, and the State's Medicaid program. Payors in this category pay seven of the rate components established under the cost control law, but they do not have to pay the differential component.

40. The second category includes all other parties which the State has included in the cost control legislation: payments pursuant to the workers' compensation law (whether by an employer, insurer or other arrangement), payments pursuant to the volunteer firefighters' benefit law, the volunteer ambulance workers' law, the no-fault auto insurance law, persons enrolled in a self-insured fund which remits payment directly from the fund to the hospital, and persons insured by a commercial insurer (so long as the insurer is licensed in New York and the insurance coverage is "expense incurred", which means it covers all types of expenses incurred in the hospital (not just a fixed amount such as $50 per day). Payors in this category pay all the eight components of rates established under the cost control law, including the payment of the differential component.

41. The third category is not really subject to the same cost control law provisions. Parties in this category pay the hospital's charges rather than the State's reimbursement rate, although such charges can not be more than 20% higher than the state specified rate for the second category (which includes all eight components of the rate). Parties included in this category include: commercial insurers not licensed in this State; commercial insurers that issue coverage on a basis such as $50 per day; self-insured plans that do not remit payments directly to the hospital, and persons who have no health insurance or health benefits plan and thus make payment out of their own pocket.

42. The Plaintiffs are included in the cost control legislation and, like the majority of other payors subject to the cost control law, are in the second category. They pay all eight components of the rates established pursuant to that law. Therefore Plaintiffs are able to obtain the benefit of making payment to hospitals at the cost control rate rather than the essentially uncontrolled charges which the hospital is otherwise free to impose.

Choices Available To An Employer

43. It is important to note that in some of the instances identified in the complaints, the Plaintiffs are subject to the cost control statute only by their own choice. For example, a self-insured plan does not have to pay the cost control rate. If a self-insured plan chooses to remit its payments to the employee or patient (rather than directly to the hospital) then the self-insured plan is not subject to the State rate setting scheme and would not have to pay any of the eight components of the rate. In that event, the self-insured plan would pay the hospital's charges. In fact, a number of self-insured plans have chosen that option.

44. An employer's eventual cost of its health benefit plan will be affected, in part, by which method the employer selects to provide its hospital benefits. Selection of Blue Cross or an HMO will have different implications than selecting insured coverage from a commercial insurer. Selection of a self-insured plan which remits payments to the employee will have different implications than selection of a program which remits payments directly to the hospital.

Differentials In Other States

45. New York is not the only State which has differentials. Both Maryland and New Jersey have formal differentials set forth in statute or regulation. Like New York, these differentials are

due, at least in part, to insurers' activities in offering health insurance on an open enrollment basis.

46. The Maryland differential is 4% for open enrollment. See attached Exhibit "A" for a copy of the findings of the Maryland Health Services Cost Review Commission. (In particular, see pages 3, 4 and 15.) However, the Maryland statute requires open enrollment for only 30 days out of each year and the benefits in the policies are limited. In contrast, for open enrollment, New York requires that coverage be offered continuously throughout the year and the benefits covered under the policy offered are quite extensive. However, the clear parallel to New York is the Maryland linkage of the differential to insurer underwriting practices which spread insurance risk in a socially desirable fashion, and in contrast to the practices of other insurers which decline to undertake those practices.

47. New Jersey also has a statutory requirement of a differential in its hospital rate setting law. Attached as Exhibit "B" is a copy of a portion of the New Jersey statute. It expressly includes the broad provision of health insurance as a factor in establishing the differential. However, the differential in New Jersey is included in hospital rates in a very different fashion than New York rates.

48. Other States such as Pennsylvania have differentials which exist in practice because the State does not have a cost control statute for both Blue Cross as well as commercial insurers. In Pennsylvania the differential ranges from 18% to 30% depending upon the region, just as New York had during the 1970's prior to NYPHRM. The Blue Cross Plans in Pennsylvania offer extensive open enrollment and the community rated premiums for the policies are significantly less than the premiums offered by commercial insurers, even to persons who have passed medical underwriting in order to obtain coverage. However, again the clear parallel to New York is New Jersey's linkage of the differential to

insurer underwriting practices which spread insurance risk in a socially desirable fashion, and in contrast to the practices of other insurers which decline to undertake those practices.

Uniformity Among States

50. The fact that New York has a hospital cost control statute while other states do not, or other states have different statutes, should not result in a finding of preemption as to New York's differential, as argued by the Plaintiffs. The NYPHRM statute simply prescribes the rate a hospital shall charge to an insurer, the State's Medicaid program, or any other payor of hospital services. The amount of the State specified rate appears on the hospital bill which the hospital renders to the insurer or payor. On the portion of the hospital bill which lists the "amount due" the hospital simply substitutes the state specified rate in lieu of what would have been the hospital's own charges.

51. No two hospitals in New York State have the same reimbursement rate. Likewise, no two hospitals had the same schedule of charges prior to (or would have, subsequent to) the rate setting law. Similarly, hospitals in other states each have their own schedule of charges or, in some cases, a state mandated rate. There is no uniformity in hospital charges or rates which would exist even in the absence of New York legislation.

52. The important point is that there is nothing in New York's hospital cost control law which requires insurers or self-insured plans to operate their employee benefit programs in a different fashion from the manner in which they are operated outside of New York. The method a hospital uses to determine how much it will bill for services rendered may be different, but that is an obligation which falls upon the hospital.

53. The amount of the hospital bill in New York will be more or less than the amount of a hospital bill in Oklahoma, but that may

be true even if the state did not regulate hospital costs at all. It is also true of other expenses incurred in providing employee benefits such as the market rate for labor, taxes or highway tolls incurred in the course of work-related travel.

CONCLUSION

54. If successful, Plaintiffs' claims would destroy an important provision in the overall scheme for regulation of hospitals and health care costs in New York State. If Plaintiffs' arguments prevail in regard to the differentials as one component of the rates, then many other components of the rate setting scheme are at risk. New York's aggregate hospital financing scheme assures hospitals enough money to function to provide the quality and availability of hospital services which State officials deem appropriate. The integrity of that system would be severely compromised by a ruling that New York lacks the authority to set hospital rates. Yet the system also strictly limits the amount which insurers and other payors must pay for hospital care in order to assure that as many patients, businesses and governments that pay for hospital care can afford to do so, since their financial reserves are obviously limited.

55. No alternative mechanism is in place to deal with this contingency, and the dislocation which would result would, at a minimum, undermine all of the State's efforts at cost containment and the financing of all hospital care in the State of New York. The precise monetary loss cannot be predicted but would be substantial, particularly for the hospitals. These losses would eventually lead to increases in expenditures of all insurers and payors and in a greater tax burden on New York State citizens.

ARTHUR B. KLEIN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn, deposes and says:

1. I am the Chief Financial Officer of Empire Blue Cross and Blue Shield (hereinafter "Empire"), a corporation organized under Article 43 of the Insurance Law. Empire is a member of the New York State Conference of Blue Cross and Blue Shield Plans (hereinafter the "Plans"). As such, I am familiar with the operation of Article 43 corporations, the health insurance system and the hospital reimbursement system in New York State and the factual issues in this litigation. I am also familiar with Empire's participation in the Government-Wide Service Benefit Plan (referred to by Blue Cross and Blue Shield organizations as the "Federal Employee Program") offered to federal enrollees pursuant to the Federal Employee Health Benefits Act. I make this Affidavit in opposition to Plaintiffs' Motions for Summary Judgment and in support of the Plans' and Empire's Cross-Motions for Summary Judgment.

2. Blue Cross and Blue Shield Plans in New York engage in a variety of practices which distinguish them from other types of insurers. For many years these differences have provided the Legislature with a reasonable basis for establishing different classes of payors under the State's hospital rate setting law. An

in-depth analysis of the historical basis of the differential is set forth in the Affidavit of Albert Antonini submitted herewith.

BACKGROUND INFORMATION

3. Empire provides health insurance coverage to more than eight million persons located primarily in New York City, the surrounding Metropolitan New York area, and Northeastern New York.

4. In 1991, Empire reimbursed approximately $2.5 billion to hospitals in New York State.

5. At the outset it should be noted that the differentials at issue only apply to inpatient hospital services. Due to an on-going shift from inpatient care to outpatient care over the past decade, inpatient hospital bills account for under 40% of the total health care services covered by the Plans. This figure is consistent with the figure offered by Aetna Life Insurance Company in the Affidavit of Burke, ¶7. Aetna states that 35% of Aetna's total costs are for inpatient hospital care. A *13%* advantage on only 40% of the total health care package translates into only a 5% competitive advantage in the total premium quote (13% x .4 = 5%).

6. It also should be noted that the increase in claims payments due to the increase in the differential from 13% to 24% for the commercial insurers of their claims payments need not require a corresponding increase in premiums or a reduction in benefits as alleged by the Plaintiffs. Most commercial insurers have substantial profit margins on insurance which could absorb—in whole or in part—the increased differential. Other insurers deliberately subsidize health insurance in order to sell more lucrative products such as life insurance. Therefore the costs will not automatically be passed along as increased costs to policyholders.

NEW YORK'S HOSPITAL REIMBURSEMENT SCHEME AFFECTS ALL INPATIENTS, NOT JUST ERISA PLANS

7. The Blue Cross and Blue Shield Plans provide health insurance coverage to a wide variety of groups and individuals.

8. For example, Empire Blue Cross and Blue Shield has a contract with the City of New York to provide health insurance coverage. At the present time, that coverage involves 372,000 contracts with city employees and retirees with premiums of more than $375 million per year.

9. In addition, Empire Blue Cross and Blue Shield and the other Blue Cross and Blue Shield Plans in New York State have a contract with the State of New York to provide hospital insurance. That coverage involves 450,000 contracts with State employees and retirees with premiums of more than $457 million per year.

10. Both the City of New York and the State of New York are governmental employers which are not subject to the provisions of ERISA.

11. On the other hand, Empire issues other large group contracts through employee benefit plans which are subject to ERISA.

12. Similarly, Empire's small group market is comprised of groups, some of which are regulated under ERISA and others that are not.

13. All of the New York State Blue Cross and Blue Shield Plans offer health insurance to persons who do not have employer health insurance and thus procure, and pay for, their own health insurance. For example, over 300,000 *persons* have direct payment (non-group) traditional insurance coverage (not counting

their spouses and dependents) with Empire. An additional 450,000 persons have Medicare Supplemental coverage.

14. None of those direct payment customers are subject to ERISA.

15. Other payors in the reimbursement system are not regulated by ERISA in any respect. For example, the State of New York and local county governments operate the Medicaid program, which provides publicly financed health benefits to millions of New York residents and receives the differential. The Medicaid program is not subject to ERISA. No-fault insurers are not regulated by ERISA, but do not receive the differential.

16. In summary, the NYPHRM hospital reimbursement system includes a broad array of payors that make payments to hospitals for rendering hospital services to a wide variety of persons covered by numerous types of programs and insurers. Some of those payors are governmental programs, some are insurers or HMOs, others are self-insured employers, and still others are programs such as volunteer firefighters or volunteer ambulance worker benefit plans.

17. The ERISA statute applies to some, but by no means all, of the employers, persons, or government agencies which ultimately pay hospital bills.

BLUE CROSS AND BLUE SHIELD PLANS ARE FUNDAMENTALLY DIFFERENT THAN COMMERCIAL INSURERS

18. The Blue Cross and Blue Shield Plans in New York State have a fundamentally different corporate mission than commercial insurers. That fundamentally different mission is the reason that the Blue Cross and Blue Shield Plans receive favorable treatment in the State's hospital rate setting statute.

19. Insurers such as the Plaintiffs in this action operate as ordinary, for-profit businesses. In most cases, the insurer collects premium income from employers and other customers and pays health care claims when they arise. Other insurers operate as mutual companies on behalf of their policyholders. Although they do not attempt to make profits as such, they attempt to provide economic benefit to their member policyholders by keeping their premiums as low as possible. In short, they provide a valuable service to their customers as a traditional insurance company, and similar to other insurance for homeowners, auto insurance, etc.

20. In contrast, Blue Cross and Blue Shield Plans are designed to undertake efforts to issue insurance to as many types of people and groups as is financially practical. For example, Empire's statement of corporate purposes calls for Empire to provide "the best possible coverage for the largest possible portion of the self-sustaining population on the most cost-effective basis." The Plans are not-for-profit. They have public representatives on the Board of Directors. They use different underwriting and premium setting methods than are employed by the commercial insurers. In short, Blue Cross and Blue Shield Plans have a corporate mission which is closely linked with State Legislative efforts to promote access to health insurance, which in turn has a significant impact on access to health care. For more details regarding the origin and purposes of Blue Cross and Blue Shield, see Exhibit A of the accompanying affidavit of Albert F. Antonini.

21. The different nature of Blue Cross and Blue Shield Plans is in part reflected in the fact that in New York, as well as most other states, the Legislature created different enabling legislation for Blue Cross and Blue Shield Plans than for other insurers. For example, Blue Cross and Blue Shield Plans are subject to prior approval of their rate increases by the Superintendent and public hearings during that rate approval process. (*See* Insurance Law §4308). Commercial insurers are not subject to either of these requirements.

22. Rochester is perhaps the most successful example of the unique role played by a Blue Cross and Blue Shield Plan in a community's intertwined health care and health insurance mechanism. Attached as Exhibit "C" is a New York Times article from August 25, 1992 which describes the impact Blue Cross has on access to health insurance and thus health care. Instead of simply performing the useful function of an insurer, the Blue Cross and Blue Shield Plans go a step beyond by acting as a catalyst to extend insurance to all segments of the community.

23. In summary, while commercial insurers and Blue Cross and Blue Shield Plans both perform the same basic insurance functions, they do so in fundamentally different ways. Based upon these differences, and to further underlying State policy objectives, the State has long treated Blue Cross and Blue Shield Plans in a different manner than commercial insurers, that different treatment has taken a variety of different forms (not just for hospital reimbursement).

THE DIFFERENT INSURANCE PRACTICES OF BLUE CROSS AND BLUE SHIELD

24. The two principal areas where the insurance practices of Blue Cross and Blue Shield Plans differ from those of commercial insurers are how they accept applications for insurance and how they set premiums for the coverage. Attached as Exhibit "D" is a report prepared by the Center for Health Policy Studies, a consulting firm in Maryland. The Report compares the insurance practices of Blue Cross and Blue Shield Plans with the practices of commercial insurers, including several of the Plaintiffs in this action, identifying significant differences between them.

25. The Plans offer community rated products meaning that premiums based upon the cost of providing health care benefits to a large pool of subscribers within a broad geographic region. The

resulting premium rate reflects the average cost and utilization of health care resources in the community as a whole, instead of the claims experience of a particular group or individual. Community rating makes premiums as affordable as possible to the greatest number of people by spreading risk over the entire pool of covered persons. This is considered good public policy because any group can be a good risk one year and a poor risk the next. So long as adequate numbers of groups with better than average experience are included in the pool to offset the groups with worse than average experience, the premiums can be set at an affordable level for all groups.

26. Empire has approximately 1.5 million small groups and direct pay (non-group) subscribers. The State-approved premiums for each kind of benefit are identical for all persons holding the same coverage, irrespective of their health or their actual need for covered services.

27. The Department of Insurance, in its regulation of the Plans over many decades, has required community rating and endorsed the valuable role that Blue Cross plays in providing such insurance. As the Superintendent of Insurance stated in a 1969 Opinion and Decision on subscriber rates, attached hereto as Exhibit "E".

> "Over the years, on of the basic tenets of Blue Cross has been the concept of "community rating"—the idea that health insurance rates should be the same regardless of whether a person is young or old, sick or healthy, where he lives or what his job is. The rates for Blue Cross should be based, under this theory, upon the experience of all subscribers, rather than having separate rates for such small classification or group depending upon the experience of that particular classification or group. *Many of the special statutory provisions for Blue Cross plans . . . were originally predicated upon the presumably unique*

community service role of Blue Cross, essential to which was community rating." (Ex. "E" at 14)(emphasis added).

28. Some Plans use community rating only for small groups consisting of from 3 to 49 employees, as well as individuals (who are referred to as direct pay subscribers) and individuals holding contracts to supplement their Medicare coverage. Other Plans, such as those in Rochester and Buffalo, use community rating even for most large groups. For example, in Rochester the Kodak Corporation pays the same premium rate as does a medium sized law firm or a small barbershop.

29. No community rating is offered by commercial insurers in New York. They often develop premiums based upon the expected claims experience of the particular group. In other cases the premiums may vary significantly based upon the age, sex and residence location of the persons insured. Premiums may rise dramatically if one or more persons in the group become ill.

30. The Plans engage in "open enrollment" which means that Empire and the other Plans offer coverage without requiring examinations or health statements as a condition of either issuing or renewing contracts. Instead, the Plans offer coverage to anyone who seeks it—good risk or poor risk. An applicant simply lists their name and address on the application, remits a check for the first premium payment, and the policy will be issued.

31. No open enrollment is presently offered by any commercial insurer in New York. In fact, commercial insurers deny coverage to many individuals and groups based on occupation, prior medical history and age. For example, the Jaymar Health Resource Book, a major tool written and used by commercial agents and brokers who sell health insurance policies to small groups, lists dozens of industries and occupations that are considered banned from commercial health insurance coverage. A sample of these

include manufacturers, air transportation companies, bars and cafes, construction companies, forestry, lumbering and logging, foundries, police officers, firefighters, oil and gas well companies, public schools, trucking companies and used car dealers.

32. Empire's periods of "open enrollment" have also been endorsed by the Superintendent. In a 1980 Opinion and Decision, attached hereto as Exhibit "F", the Superintendent of Insurance commented on the benefits of Blue Cross' open enrollment periods:

> *The availability of health insurance for all New Yorkers is of paramount importance to the Superintendent of Insurance.* Blue Cross/Blue Shield of Greater New York is commended for fulfilling its basic purpose of serving the needs of the community through its periods of open enrollment and, it is expected that the Plan will continue to serve this purpose by conducting similar periods of open enrollment in each of the coming years. Emphasis added. (Ex. "F" at 13).

33. In almost all cases, the Plans operate at a loss with respect to coverage of direct pay (non-group) persons. This includes Medicare supplemental coverage for the elderly. These policies are offered at a premium rate lower than the Plans' actual costs because this category of customers typically has difficulty affording the premium payments. Since the coverage is offered at a loss, the Plans price some of their other policies at a slightly higher rate.

34. In contrast, many commercial insurers do not even offer health insurance to direct pay (non-group) customers.

35. As a major part of its community rated business, Empire supplied Medicare Supplementary Coverage in 1991 to approximately 450,000 elderly New Yorkers. This coverage supplements

the benefits received from Medicare Part A (hospital) and Medicare Part B (medical), assisting Medicare recipients to pay the large Medicare deductibles and to fill other gaps in Medicare coverage. In 1987 to 1990, community rated Medicare supplemental losses amounted to almost $150 million statewide among the Plans.

36. In contrast, only a few commercial insurers (eight as of 1991) even provide this type of Medicare supplemental insurance in New York State. In fact, most of the named insurance company Plaintiffs in this action, such as Travelers Insurance Company and Aetna Life Insurance Company, do not offer these coverages.

37. The Blue Cross and Blue Shield Plans undertake insurance practices that a purely profit minded insurer would abandon in the heat of a competitive marketplace. The differentials assist the Plans in remaining competitive in the overall insurance marketplace and thereby maintain a sufficiently large base to support their community oriented coverage programs. Without such a base, the Plans would not be able to provide millions of New Yorkers with the type of affordable coverage desired by the Superintendent of Insurance and the Legislature. Those millions of New Yorkers who benefit from community rating—and in particular, the lower income, older and less healthy individuals who are able to remain self-sufficient by enrolling in Blue Cross, will be the losers if the differential is no longer available to the Plans.

38. Loss of the differential would result in a larger uninsured population in New York State. There is a correlation between the number of uninsured persons in a state and whether insurers in that State offer open enrollment for health insurance. States where insurers offer open enrollment have incidents of uninsurance that are twenty to thirty percent less than the national average. *See* the attached Exhibit "G" which contains portions of a national study which uses official Census Bureau and General

Accounting Office figures to report the number of uninsured persons in each State in relation to whether that State offers open enrollment. A summary based upon that data, which is also attached, demonstrates that the eleven States with open enrollment have 2.8 million fewer uninsured persons than the national average. New York, in particular, has 20.8% less uninsured persons than the national average. Many of the States listed also have differentials in hospital rates, as described in the accompanying Affidavit of Arthur B. Klein ¶¶ 45-48.

THE PLANS ENGAGE IN MANY PUBLIC HEALTH ACTIVITIES WHICH ARE DIFFERENT THAN OTHER INSURERS

39. The Plans also are different from commercial insurers due to the enormous financial stability the Plans give to hospitals and other providers. There are numerous programs in which the Plans participate which encourage cost containment and produce a quantifiable benefit to the community.

40. The Plans promote the financial stability of hospitals in two ways. First, the Blue Cross and Blue Shield Plans in the state provide hospitals with advance p[illegible]ents in anticipation of claims of some $300 million in the aggregate. This working capital advance is of extreme importance to the operations of the hospitals because it lessens the need of the hospitals to engage in expensive short term borrowing. Without it, the hospitals would be in immediate fiscal crisis. In contrast, commercial carriers pay hospitals long after patient care costs are incurred, and without providing any cash flow in the interim. There have been some estimates made that it takes commercial insurers 84 days to pay for inpatient hospital services for their insureds.

41. Secondly, by providing insurance to many tens of thousands of persons who otherwise would have no access to it, the Blue Cross and Blue Shield Plans substantially increase the num-

ber of patients for whose care hospitals receive full reimbursement, thus reducing the hospitals' bad debt and charity care problems.

42. The Plans have also exhibited a high degree of responsiveness to public policy initiatives. Empire was, for example, the only insurer to respond positively to requests for statewide fiscal intermediaries for the Department of Health's prenatal care demonstration project.

43. The Plans have enrolled over twenty-five thousand previously uninsured children in a new program called Child Health Plus which is administered by the State. Commercial insurers were invited to participate but declined even to submit proposals to be included in the program.

The Deterioration Of The Plans' Position In The Marketplace

44. Empire's community rating approach has made it vulnerable to the predatory risk selection criteria of the commercial carriers who offer health insurance *only* to the good risks, i.e., persons whose costs are less than the average reflected in the community rate. Those persons could obtain lower rates by leaving the community rated programs and obtaining coverage from other insurers who base premiums on a group's own favorable claims history.

45. The application of risk selection criteria employed by the commercial health insurance carriers to target and skim only the good risks from the Plans' community rated pools is commonly referred to as "cherry picking".

46. For example, certain commercial insurers seek only good risk groups and avoid or blacklist groups that are potential bad risks by selecting who they will insure based on health statements, physical examinations and tests, the exclusion of certain

industries, and other exclusionary factors such as age, sex, and geography.

47. Skimming or cherry-picking by certain commercial insurers of Empire's good risk groups has greatly accelerated since the late 1980's to the present. Over the last four years, Empire has lost more than 600,000 of its small group customers, roughly 47% of its small group pool. Ninety percent of these lost customers were good risks.

48. From 1988 through 1990, net contract losses in Empire's community rated small group pools averaged approximately 72,000 per year. During 1991, however, contract losses accelerated resulting in 90,000 contract losses, nearly 25% higher than the average annual loss of the previous three years.

49. Cherry-picking has had a dramatic impact on Empire's pools of community rated coverage. In 1986, the ratio of good risks to poor risks was 10:1. Currently the ratio is only 3:1 because of the commercial insurers' cherry picking.

50. Over the past several years, Empire has experienced a decline in enrollment of the groups under 50 persons. In 1988, the Plans had 1.8 million New Yorkers enrolled in small groups as compared to 1.2 million three years later. This decline has contributed greatly to the overall community losses which for Empire alone were $175 million in 1991. Coupled with this loss in enrollment has been a deterioration in the underwriting results produced by the remaining groups. For example, despite the decline in enrollment, total claims cost for the Plans on small groups increased by over 23%.

51. As the Superintendent himself has repeatedly noted, cherry picking by commercial health insurance carriers will eventually lead to the collapse of the community rated pools. As more of the good risks leave, resulting in a higher percentage of poor risks

submitting higher numbers of claims, premiums are driven up, which causes more good risks to leave with the result that premiums eventually will become too expensive for those left in the pool. *See* p. 11 of April 1, 1992 Decision, Exhibit "Q" to the Affidavit of Antonini.

52. Absent rate relief from the Superintendent, the 1992 underwriting loss sustained on Empire's community rated contracts is projected to be $270 million, plus an additional $850,000 loss on special programs offered to persons unable to afford health insurance, such as the special program for uninsured children. These losses would obviously be significantly higher if the benefit of the differential in payments for inpatient hospital services was no longer available.

1992 CHANGES IN THE DIFFERENTIAL

53. In order to ensure the Plans' ability to cover high risk residents in New York State, especially in light of the deterioration of the Plans' community rated pools, the Legislature increased the differential effective April 1, 1992 for commercial insurers from 13% to 24%. The 11% increase applies only to insured policies issued by commercial insurers; the 11% increase does not apply to any other insurers or payors subject to the 13% differential, such as no-fault auto insurers, workers' compensation programs, self-insured funds paying the hospitals directly, etc.

54. The differential rate component was increased for commercial insurers because the Legislature believed that the insurance underwriting practices of commercial insurers were disruptive to the insurance markets as well as an obstacle to the public's efforts to purchase health insurance. As explained and documented in the accompanying Affidavit of Albert F. Antonini, the Legislature had been debating an increase in the differential for some time. Although the Legislature eventually decided to divert the additional revenues from the extra 11% to the State Treasury, that does not change the underlying intent to increase the differential by an additional 11% for exactly the same reason that the basic 13% differential already existed. In adopting the 11%, the Legislature essentially was restoring the differential for commercial insurers to the 25% range which existed throughout the 1970's and early 1980's.

55. The increase in the differential is intended to help stop the cherry-picking. Community rated groups tempted to leave the Plans will now have to think twice as hard about that decision, because the differential advantage they would be giving up by abandoning the community insurance pool would be much more (24% instead of 13%). *See* remarks of Superintendent of Insurance Curiale set forth in Exhibits "O" and "P" of accompanying Affidavit of Albert F. Antonini.

56. The Plaintiffs are well aware that the differential is favorable treatment offered to the Plans to offset the increased costs inherent in their open enrollment and community rating insurance practices. On March 5, 1992, at a public hearing convened by the State Senate Committee on Insurance to discuss legislation regarding community rating, testimony was offered by Chris Peterson, a senior counsel for Plaintiff Health Insurance Association of America. Mr. Peterson stated "they [Blue Cross] were granted 13 percent to pay for the cost of open enrollment and community rating." *See* attached Exhibit "H". While the remaining portions of the debate revolved around whether the 13% should be increased or decreased, it is clear that Plaintiffs acknowledge that the favorable treatment offered to Blue Cross in the hospital rate setting system is recognition of the Plans' insurance practices such as community rating and open enrollment.

HMO DIFFERENTIAL

58. That the Plans "earn" the differentials by engaging in activities not engaged in by other insurers is illustrated by the enactment of a differential in 1992 for HMOs. Since HMOs began in this State they have been afforded the same favorable treatment as the Plans. This is due in part to the fact that the first HMOs in the State (such as HIP-Health Insurance Plan of Greater New York) were created as not-for-profit corporations under Article 43 of the Insurance Law, just like Blue Cross.

59. Furthermore, HMOs were expected to enroll applicants without an underwriting process or excluding pre-existing conditions, and to price their coverage using community rates rather than the claims experience of the particular employer. *See* 10 NYCRR, Part 98.6(1).

60. Over the past few years some HMOs failed to live up to those requirements and incurred the wrath of regulatory officials who claimed that not all HMOs were performing the public service type insurance enrollment activities which were the basis for offering favorable treatment to HMOs in the hospital cost control statute. For example, see statements of Superintendent of Insurance Curiale at public hearings urging legislation requiring HMOs to perform open enrollment insurance activities. *See* Exhibit "P" to Affidavit of Albert F. Antonini, pages 11 and 14. In fact, the Legislature did enact such a requirement in July 1992. *See* Amendments to §4406 of the Public Health Law, at ¶17 of Chapter 501 of the Laws of 1992.

61. As referred to above, the Health Department regulations require HMOs to provide a variety of community services, including efforts to enroll Medicaid patients in insured HMO coverage where the State pays a fixed insurance premium rate to the HMO. For many years a controversy has existed between the

State and some HMOs regarding whether some HMOs were executing such contracts at a reasonable pace.

63. In April of 1992 the State adopted legislation which took part of the differential away from the HMOs (9%) and permitted the HMOs to recapture the full differential if the individual HMO had indeed entered into insured premium arrangements with the State and enrolled targeted numbers of Medicaid patients into those insured arrangements. Like the additional 11% differential on commercial insurers due to their discriminatory underwriting practices, the money from the new 9% differential on HMOs was diverted to the State General Fund, rather than the traditional hospital recipients of the differential monies. However, the diversion of receipt of those funds to the State Treasury does not change the purpose of the underlying HMO 9% differential, which was to encourage HMOs to expand their offering of insured coverage to include persons enrolled in the State's Medicaid program. The new HMO 9% differential is thus just like the other differential because it is designed as a "carrot" or incentive for an insurer (in this case an HMO) to undertake expanded insurance enrollment activities.

63. It should be noted that the new HMO 9% differential affects Blue Cross and Blue Shield as well. The Plans operate five different HMOs in New York State. The HMO operated by Blue Cross and Blue Shield of the Rochester offers extensive insured HMO coverage to the Medicaid population and qualifies for a full waiver of the 9%. The four HMOs operated by the other Blue Cross and Blue Shield Plans, including Empire Blue Cross and Blue Shield, are not extensively enough engaged in providing insured coverage to the Medicaid population to qualify for a waiver and thus will now pay an additional 9% on hospital inpatient reimbursement rates.

EMPIRE'S PARTICIPATION IN THE FEDERAL EMPLOYEE PROGRAM

64. The United States Office of Personnel Management ("OPM") contracts with several carriers which offer experience-rated health insurance plans and health maintenance organization benefit plans to federal enrollees under the Federal Employees Health Benefits Program. 5 U.S.C. §8903; 48 C.F.R. §1601.101(b). Some of the experience-rated plans are underwritten by Blue Cross and Blue Shield organizations and some by commercial health insurance companies.

65. Empire Blue Cross and Blue Shield provides benefits in its service area to federal enrollees through its participation as an underwriter of the Government-Wide Service Benefit Plan. The Government-Wide Service Benefit Plan is an experience-rated health insurance plan. 48 C.F.R. §1615.802.

66. The carriers for the experience-rated Federal Employees Health Benefits Program plans receive premium income, pay the expenses of the plans (including claims expenses, administrative expenses, taxes, etc.) from the premium income, account to the government for the resulting excess or deficit, and hold an excess for the benefit of the plan in future years. Carriers are liable for the claims of their enrollees if the premium income and the government's contingency reserve are insufficient to pay claims. 48 C.F.R. §1602.170-6; 48 C.F.R. §1615.905; 48 C.F.R. §1616.102(b).

67. The enrollment charges for the Federal Employees Health Benefit Program plans are the sum of the carriers' premiums and additional charges by the OPM. Annually, the carriers and OPM agree on premium rates, a 4% factor is added to the premium rates, and the sums of those amounts (total enrollment charges) are collected by deduction from federal employees' pay and from annuitants (approximately 40%) and contributions from federal

payroll offices and the OPM for annuitants (approximately 60%). 5 C.F.R. §890.502.

68. The enrollment charges for the Federal Employees Health Benefits Program plans are paid to the Employees Health Benefits Fund; 1/104 of the enrollment charge is credited to OPM's administrative reserve, 3/104 is credited to OPM's contingency reserve, and 100/104 is made available to the carrier through a letter of credit account in the United States Treasury. 48 C.F.R. §1602.170-9; 5 C.F.R. §890.503. In addition, amounts are made available intermittently from OPM's contingency reserve to the letter of credit accounts. 5 U.S.C. §890.505; 48 C.F.R. §1652.216-71; 48 C.F.R. §1652.232-70. The letter of credit is irrevocable (the equivalent of cash) for the payment of benefits under the health benefits plans. 31 C.F.R. §205.5. OPM requires carriers to account for all amounts made available from the Employees Health Benefits Fund to the carriers' letter of credit accounts as premium income.

69. The carriers of the experience-rated plans are required to account for the income and expenses of the plans. 48 C.F.R. §1652.216-71. Carriers' allowable charges to the contracts are determined by the Federal Acquisition Regulation as implemented by the Federal Employees Health Benefits Acquisition Regulation. 48 C.F.R. Ch. 1; 48 C.F.R. Ch. 16. In general, carriers are permitted to charge State and local taxes to their experience-rated contracts as administrative expenses. 48 C.F.R. §31.205-41. Prior to 1992, however, carriers were required to report State premium taxes separately as "other charges". 48 C.F.R. §1652.216-71. At least one Blue Cross and Blue Shield organization that was subject to a State tax for assessment measured by the number of its enrollees participating in the Government-Wide Service Benefit Plan reported those taxes to OPM prior to 1992 as premium taxes.

70. The Federal Employees Health Benefits Act was amended, effective January 1, 1992, to preempt certain State taxes relating to payments to carriers from the Employees Health Benefit Fund. Public Law 101-508, §7002(c), 104 Stat. 1388; 5 U.S.C. §8909(f)(1). OPM implemented that change in law by amending the Federal Employees Health Benefits Acquisition Regulation to provide that carriers cannot charge taxes measured by premiums to their experience-rated contracts after 1991. 48 C.F.R. §1631.305-41.

71. Subsequently, OPM considered whether the differentials in hospital reimbursement rates are preempted by 5 U.S.C. §8909(f)(1). In a letter dated August 25, 1992, OPM advised the Superintendent of Insurance for the State of New York that §8909(f)(1) preempts the 11% differential and the 9% differential with respect to HMOs. A copy of the OPM's letter dated August 25, 1992, is attached as Exhibit "I".

72. The operation of the differentials in hospital reimbursement rates is wholly unrelated to the amount of premiums paid by federal enrollees or even the number of enrollees. In fact, the insurance companies and third party administrators of health benefits plans are not required to account for or report the amounts of their insurance premiums and enrollees in the State of New York to hospitals in the State of New York.

CONCLUSION

73. Over the decades since the development of the Blue Cross and Blue Shield movement, the Plans in New York State have continually been accepting the social responsibility of providing health insurance to the broadest spectrum of New Yorkers. Going well beyond offering health insurance as a necessary business commodity, the Plans undertake a public policy mission to offer health insurance to as many persons as is practical. Many of those persons could not obtain coverage at all from other insurers; other

persons would be offered coverage but, as a result of the premium setting methodology utilized by other insurers, could not afford it. In addition, the Plans offer substantial cash flow assistance to hospitals which other insurers do not.

74. Based on the substantial differences between types of insurers, when the Legislature created a hospital cost control law it offered different hospital rates to Blue Cross in light of Blue Cross' different health care and health insurance practices. There was no intent to provide undue favoritism to Blue Cross or to be punitive towards other payors. The reasonable differentials in hospital rates simply reflect the Legislature's evaluation of the magnitude of the differences between the Blue Cross and Blue Shield Plans and the financial advantage in hospital rates which the Blue Cross and Blue Shield Plans need in order to attain the goals the Legislature has established.

JERRY WEISSMAN

[Jurat ommitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Albert F. Antonini, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ALBERT F. ANTONINI, being duly sworn, deposes and says:

1. I am the President and Chief Executive Officer of Blue Cross and Blue Shield of Central New York, Inc. which is a member of the New York State Conference of Blue Cross and Blue Shield Plans. I presently serve as Chairman of the Conference of Plans.

2. I have been employed by Blue Cross and Blue Shield of Central New York (and its predecessor corporations) since 1954 and have been President of the corporation since 1982. I am fully familiar with the operation of the hospital reimbursement system and the operation of the health insurance system in New York State. In particular, I am familiar with the differential in hospital reimbursement rates challenged by the Plaintiffs in these actions and its historical role in the State's regulation of insurance. I execute this Affidavit in support of the Plans' and Empire's Cross-Motion for Summary Judgment on the basis that the laws creating the differentials are not preempted by ERISA.

A. THE PLANS

3. The Conference of Plans is an unincorporated association consisting of all six Blue Cross and Blue Shield Plans which operate as Article 43 corporations in New York State.

4. The Plans are: Empire Blue Cross and Blue Shield, Blue Cross and Blue Shield of Utica-Watertown, Inc.; Blue Cross and Blue Shield of Central New York, Inc.; Blue Cross and Blue Shield of the Rochester Area, Inc.; Blue Cross of Western New York; and Wholehealth Insurance Network, Inc. (d/b/a Blue Shield of Western New York and Blue Shield of Northeastern New York).

5. The Plans are not-for-profit health service corporations, organized and operating pursuant to Article 43 of the Insurance Law. The Plans provide coverage for hospital and health-related services to more than 12 million subscribers, with Empire Blue Cross and Blue Shield alone providing coverage to more than eight million subscribers. The Plans contract with hospitals to provide covered hospital services under the terms of applicable subscriber contracts and pay the hospitals for such services at rates set by the New York State Commissioner of Health. The hospitals, in turn, must accept the reimbursement as payment in full for these services provided to the Plans' subscribers.

6. As not for profit health services corporations, the Plans are subject to extensive regulation and oversight by the Superintendent of Insurance of the State of New York (hereinafter "Superintendent"). The Superintendent's regulatory authority over the Plans includes broad audit powers (Ins. L. §309), approval of the contracts with subscribers (Ins. L. §4308), prior approval of premium rates for all such subscriber contracts after a public hearing process (Ins. L. §4308), oversight and responsibility for the Plans' maintenance, and restoration of required statutory reserve levels (Ins. L. §4310), enforcement of the

statutory limitations on expenses (Ins. L. §4309) and permissible investments (Ins. L. §4310). This is a more extensive regulation than applied to the commercial insurers.

B. THE DIFFERENTIAL IS DESIGNED TO REGULATE INSURERS

7. While the differential is set forth in the Public Health Law, it is nevertheless a tool of State regulation of insurers and the business of health insurance. In fact, State policy regarding public health and health insurance are intricately intertwined. No other type of insurance (such as life insurance or property and casualty insurance) is as interrelated with the discipline or subject matter which it is providing insurance for, as is health insurance. That unusually tight relationship between public health and health insurance accounts for the fact that statutes, studies and discussions of the differential mention public health at the same time as they mention insurance, or do not always clearly delineate between them.

8. The concept of the differential and its purpose is actually quite simple. Commercial insurers obtain a competitive advantage in the health insurance markets when they are able to carefully select the persons they will insure by excluding persons who are ill, excluding industries where people are likely to become ill or excluding persons, through risk factors such as age and sex, otherwise at high risk for illness or disease. Thus, commercial insurers obtain a significant competitive advantage in the health insurance markets by insuring only good risks. In contrast, the Blue Cross Plans offer policies to anyone who applies (called open enrollment) and set premiums for many policies by charging the same amount to all customers, without price adjustments based on age or sex or their history of claims (called community rating). These and other practices are always good public policy but not always good business practices in a competitive marketplace.

9. The differential operates in the following manner: Suppose a Blue Cross Plan and a commercial insurer each insure 1,000 people per year. And also assume that if you took 1,000 people at random from New York State, their total hospital bills for a year would be $1,000,000. This means that the average cost of hospital care is $1,000 per person.

10. If, however, you carefully selected 1,000 persons who are healthy and issued coverage only to them, their total hospital bills for a year would be significantly less, assume $769,000.00. This means that the average cost of a healthy person is $769 per year.

11. The insurer that carefully selects the persons it will accept obtains a competitive advantage (its cost is $769 per person). The insurer which accepts every applicant has a higher price (premium of $1,000 per person) and will be under competitive pressure to abandon its practice of accepting all applicants in order to match the lower prices of its competitors for the good risks.

12. However, if the insurer that accepts every application now decides to discontinue that practice in order to stay competitive with the other insurer, many persons who are ill would no longer be able to obtain health insurance. They will either have to go without any health insurance (which is impractical since they are ill and will need to pay for their care) or if they are poor or become poor as a result of their expenditure for health care, they will become eligible for the State's Medicaid program (which is a taxpayer financed program). From the Legislature's perspective, both of these options are unacceptable.

13. The differential is the State's mechanism to attempt to level the competitive marketplace to accommodate the desired public policy practices of other insurers, such as the Plans who accept all applicants for coverage. The differential attempts to offset the competitive advantage which commercial insurers obtain by requiring commercial insurers to pay more to hospitals. In an effort

to balance out the insurance marketplace, the differential requires commercial insurers pay more for inpatient hospital care, and thus the premium rates charged by commercial insurers are closer to the premium rates charged by the Plans, whose premiums are higher because they insure individuals and groups who utilize greater health care services.

C. HISTORICAL USE OF DIFFERENTIAL TO REGULATE INSURANCE MARKETS

14. The public policy basis for the differential is well documented and is the subject of many reports and investigations spanning decades. Written references to the differential as necessary to facilitate the different practices of not-for-profit insurers as compared to commercial insurers can be traced from 1958 to the present.

The Trussell Report

15. In 1958, Governor Rockefeller commissioned a report regarding the public health and insurance questions then facing the State. A Columbia University Professor named Raymond Trussell was selected to produce the report which was entitled, "Prepayment for Hospital Care in New York State", portions of which are attached hereto as Exhibit "A".

16. Significantly, the starting point for the discussions of the public health and insurance issues presented was a discussion of the development of Blue Cross and Blue Shield Plans and notes the distinction between the services and purpose of Blue Cross and Blue Shield Plans as not-for-profit health insurers compared to the activities of commercial insurers. The report stated that the distinction began in New York State in the 1930s when separate statutes were enacted for Blue Cross and Blue Shield regulation as opposed to those of traditional commercial insurers. The historical summary noted, on page 16, that the fundamental concept

of Blue Cross is to spread the risk to the greatest extent possible. The Trussell report also noted that given the difference in the intent to create not-for-profit health service plans such as Blue Cross and Blue Shield in contrast to those of commercial insurers, the Plans have different privileges and obligations within the State regulatory scheme.

17. In the text of the report it noted the beginnings of the opportunity for "cherry-picking", which is the marketing practice of an insurer which only seeks new customers whose medical costs are lower than average, and rejects or avoids potential customers whose medical costs are above the average. On page 44, the report concluded that:

> as a general observation it may be said that, while ideally the Blue Cross Plans should accept any person who presents himself for membership, the Plans find that unrestricted enrollment tends to add persons in relatively poor health without the compensating balance of persons whose health is relatively good. If we could assume that Blue Cross had a representative cross-section of the community, unrestricted enrollment might be a possibility. As it is, [other] insurance companies through experience rating, select out of the community many of the groups whose members are in relatively good health. The Blue Cross Plans, therefore, denied the possibility of compensating for the very worst health risks with coverage for the very best, must either restrict enrollment for everyone or raise rates for everyone. Blue Cross has limitations imposed by the competitive environment in which it finds itself. If public policy requires an unrestricted right for everyone to join Blue Cross, a means must be found to supplement Blue Cross income by public subsidy or by requiring all health insurance carriers to charge premiums calculated on level lifetime premium based on actuarial lifetime utilization projection.

18. The Trussell report, issued over thirty years ago, lays out the same public policy framework for providing advantages to certain insurers in the marketplace, such as the Plans, which engage in activities directed toward fulfilling public goals. The public policy goals and the efforts to reach those goals have not changed since that time.

19. In discussing rising hospital costs and the impact which those costs have on premiums for health insurance, the Trussell report concluded that if the not-for-profit health insurance concept was to survive, Blue Cross costs could be reduced by taking only the "low risk" groups for membership in Blue Cross, which would reduce the costs to the Plan. However the report noted that "Blue Cross is intended to serve the entire community, not just those who need less hospitalization."

20. In the 1950s, the State did not have a State-imposed hospital cost control system. Instead Blue Cross Plans negotiated with hospitals to obtain discounts or agreed-upon reimbursement methodologies, which the Blue Cross Plan would pay instead of the hospitals' own established charges. In reviewing these various methodologies, the Trussell Report noted that when negotiating discounts the first major negotiable item is the amount of the discount to be given and that the discount (another word for the differential) represents a recognition of the community concept and purpose of the Blue Cross Plan. Thus, the Trussell report set forth the first written acknowledgment of the correlation between the fact that Blue Cross Plans pay hospitals less than other payors pay, and the fact that it is Blue Cross' public service activities which entitle it to that discount.

The Folsom Report

21. Several years after the Trussell Report, the Governor created a Committee on Hospital Costs chaired by Marion Folsom. This Committee issued a report in 1965 which primarily focused

its attention on hospital cost control issues. However, the "Report of the Governor's Committee on Hospital Costs", portions of which are attached as Exhibit "B", noted the fact that Blue Cross Plans were moving from community rating to experience rating which commercial insurers traditionally utilized. *See* Exhibit "B" at pp. 58 and 59. The report noted that the reason why Blue Cross Plans were motivated to implement experience rating was in order to compete with insurance companies which did not practice community rating. *See* Exhibit "B" at p. 59. The Folsom report concluded that it was vital to the community interest to share the costs of those persons who need large amounts of hospital care, not step back from that long-standing position. The report stated that the Plans best serve the community needs when they maintain the broadest possible risk-sharing. The community and hospitals in turn have given the Plans advantages (payment of lower hospital rates, and a tax exemption) so that they could continue those policies to the community as a whole. The report went on to say that a system that "gravitates toward serving favorable risks, and leaves unreined the excess costs to high users, is not meeting this social need."

22. The report urged Blue Cross Plans to reconsider moves away from community rating and broad risk-sharing and recommended that rather than resorting to experience rating Blue Cross seek aid for such high-cost groups from public funds. While access to public funds was not any more feasible in the 1960s than it is in the 1990s, the Folsom report clearly establishes the link between the preferential hospital reimbursement treatment which Blue Cross receives with the community service activities which Blue Cross performs by insuring high-risk subscribers that other insurers do not.

The Move Towards An All-Payor Reimbursement Method

23. As health care costs continued to rise in the 1970s, the State's decision to regulate inpatient hospital rates only for the

publicly financed Medicaid program, for Blue Cross and Blue Shield and HMOs was questioned. Costs were rising for commercial insurers, workers compensation, no-fault auto insurers, ambulance and Fire Department volunteers and self-insured plans as well. Furthermore, there was a general feeling that an effective and equitable hospital cost control system would have to regulate revenues from all payors. *See* discussion of hospital reimbursement schemes in New York set forth in the Affidavit of Arthur B. Klein submitted herewith. To begin to address this problem the Legislature created the Council on Health-Care Financing. The Chair and Vice Chair of the Council were the chairs of the Senate and Assembly Health Committees, and the members were persons prominent in the hospital and insurance fields. The Council continues today and almost all major hospital reimbursement legislation since 1978 has emanated from the Council's activities.

24. In previous years, there was a differential, but it was not set forth in statute. From the 1940s until 1982, commercial insurers paid the hospital's charges. Blue Cross paid either an amount negotiated with the hospital (until 1969) or a rate set pursuant to the State's original hospital cost control statutes (from 1970 through 1982). The difference between the regulated hospital rate paid by Blue Cross and the (essentially) unregulated hospital charges paid by commercial insurers was "the differential." During this period, the de facto differential ranged from 25% to 40%, although it varied by hospital and was greater in some regions of the State than other regions. As the Council on Health-Care Financing grappled with the many issues involved in developing a more comprehensive system, the differential was one of the most controversial issues the Council faced.

25. Council staff produced a paper regarding the differential, a copy of which is attached as Exhibit "C". On pages 9 and 10, the Council articulated that the differential is due to the different types of customers each insurer accepts, and the desirable impact

of Blue Cross' activities on the New York State community as a whole.

26. In 1980, the Council issued its first major report on establishment of a comprehensive hospital rate-setting system entitled "Recommendations for Financing Hospital Inpatient Care", portions of which are attached hereto as Exhibit "D". At principle 6 of the report, the Council acknowledged that "a prime consideration in establishing a payment differential is to reflect economic advantages or disadvantages and social considerations generated by differing operational policies and practices [of insurers]. *See* Exhibit "D" at pp. 92 and 93.

The First SHRPC Komaroff Report

27. In 1983, the State's first legislation affecting all insurers and payors of hospital care took effect. The system is referred to as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). NYPHRM included a differential specified in statute for the first time. The differential ranged from 12% to 15%, depending on what the differential was previously at each hospital. In addition, the new statute called for a review of the appropriateness of the differential.

28. The differential was studied by the State Hospital Review and Planning Council ("the SHRPC"), which is the body designated in the Public Health Law to adopt hospital reimbursement regulations, as well as regulations governing quality of care in hospitals and the public need for identical hospital facilities. The SHRPC's review was chaired by Stanley Komaroff, Esq., (the first Komaroff Committee). A copy of this first Komaroff Report is attached as Exhibit "E".

29. The Komaroff Committee requested and received position papers from interested parties. Interested parties submitting position papers included Plaintiff Health Insurance Association of

America, the Blue Cross and Blue Shield Plans, the State Insurance Department, individual insurance companies and self-insured plans. It is noteworthy that no individual hospital, or any of the regional or Statewide hospital associations, appeared at Committee meetings to submit arguments regarding the differential, and the debate was therefore conducted among insurers and about insurance.

30. A brief but eloquent statement of what the differential is about was provided by Dr. Saward, a member of the Komaroff Committee. His two-page letter to other members of the Committee dated April 22, 1985 is attached as Exhibit "F". Dr. Saward was from Rochester which has long been a bastion of community rating and open enrollment. Out of the hundreds of documents available regarding deliberations over the purpose and appropriate size of the differential, Dr. Saward concisely noted that the purpose of the differential is to promote insurance coverage to the maximum proportion of the population, and that the differential (and indeed even the insurers themselves) is simply the tool of State policy to attain that goal.

31. The first Komaroff report in 1985 was guided by five principles set forth on pages 3-4 as follows:

1. Hospital charge differentials, at least within New York State, should continue to be appropriate means to enable the State to achieve certain social policy objectives, including providing hospitals with certain levels of working capital and encouraging the availability of substantial and affordable health insurance for its citizens, regardless of health status or insurability.

2. Differentials should be structured to encourage payors to (a) provide insurance protection, and prac-

tices which meet social policy objectives and (b) promote hospital cost savings.

3. Although the degree of any differential shall be based on all relevant factors, both objective and subjective, no specific mathematical formula is possible; the basis of the differential is not currently susceptible of precise quantification, and historically has not been so.

4. Recommendations for change should be conservative, i.e., cautious and gradual, in recognition of the fragility of the healthcare financing reimbursement system.

5. Payor equity should not be achieved at the expense of provider inequity.

32. After establishing broad access to insurance as a principle of the review, the Report went on to conclude (on page 6) that:

> With respect to coverage practices, Blue Cross/Blue Shield is the exclusive dominant factor in the health industry in three important categories, for which the Committee believes a differential is warranted. First, Blue Cross provides individual (direct pay policies) and small group policies, without medical underwriting and at state-approved community rated premiums (meaning premiums that are not age or sex rated nor based on the level of health risk). Second, it provides Medicare supplemental insurance to more than 1 million people in its community rated pool. Thirdly, it provides insurance coverage to more than 5 million people at community-based rates pursuant to which it is able to attract sufficient numbers of healthy, low risk subscribers at attractive prices. In effect, these low risk subscribers subsidize a higher-than-

average claims cost of the high risk in this community rated pool.

33. The Komaroff Committee believed that Blue Cross' community rating practices were achieving key social policy objectives of making insurance coverage available in situations where other insurers did not, and providing subsidized insurance coverage for vulnerable groups such as the elderly, and that some significant differential was necessary for Blue Cross to maintain its then current ratio of low risk subscribers compared to high risk subscribers.

34. Perhaps the best evidence of the differential as a tool to regulate insurance is found in the recommendations of the Committee. *See* Exhibit "E", Recommendation 1 on page 8 and Implementation Issue 6 on page 12. The first recommendation was that if the differential was to remain at its level of 13%, the Blue Cross Plans should expand their community service activities. The Committee also recommended that individual commercial insurers be permitted to obtain lower differentials by engaging in the types of community service insurance activities which the State desired, and which to date only Blue Cross engaged in. *See* Exhibit "E", Implementation Issue #5 on Page 12. Thus, the Committee was using the differential as an incentive to encourage both Blue Cross and insurers to engage in more public policy oriented insurance activities.

35. The Committee concluded its report by noting that the thrust of its remarks coincided with the work of the Subcommittee on Insurance of the Legislature's Council on Health Care Financing regarding the use of hospital financing mechanisms to achieve health insurance goals. *See* Exhibit "E", Implementation Issue 7 on page 13.

Measurement Of Insurer Activities To Obtain The Differential

36. In 1988, the Legislature enacted revised hospital reimbursement legislation. As a part of that legislation, the Legislature established the differential at 13% for all hospitals' rates, but included provisions allowing the differential to fluctuate based on the insurers' own activities, as recommended by the first Komaroff Committee. *See* Public Health Law § 2807-c(11)(i) as set forth for 1988-1990 in the attached Exhibit "G". In fact, under the 1988 legislation, the differential for all Article 43 corporations such as Blue Cross would decrease from 13% to 11% if the Blue Cross Plan did not offer hospital and medical insurance on an open enrollment basis continually throughout the year. In response, at least one Blue Cross Plan expanded its open enrollment activities from 30 days per year to year-round in response to the more demanding standards set forth in the new legislation.

37. A second provision stated that an individual commercial insurer could obtain an 11% differential for itself (while other commercial insurers and other payors continued to pay a 13% differential) if that commercial insurer offered open enrollment for hospital and medical insurance.

38. The law stated that the determination of whether insurers met the requirements would be made by the Superintendent of Insurance. The same legislation required the Superintendent to establish standards and criteria for measuring insurer performance to determine whether the differential should be adjusted. *See* page 46 in attached Exhibit "G", which added a new § 335 to the Insurance Law.

39. The Insurance Department promulgated a regulation (11 NYCRR Part 42) to implement the new statute. Periodically the Superintendent requested that the affected insurers document their entitlement to the differential. Attached as Exhibit "H" is a copy of a sample letter sent by the Superintendent to insurers.

Also attached is a typical response submitted by the Blue Cross and Blue Shield Plans to document that they provide the community service types of insurance which the Superintendent of Insurance requires to qualify for the differential.

40. The Superintendent also issued a report to the legislature regarding insurer compliance, as required by the new law. A copy is attached as Exhibit "I". The report notes on page 3 that no commercial insurer responded to the initiative to stimulate insurers to offer open enrollment. The report also found that all of the Blue Cross Plans were in compliance, although opportunities for improvement such as broader advertising of community rating, were identified and agreed to by the insurers.

Statutes Regarding Reviews of the Differential

41. The same legislation which established the statutory requirements of formal reviews of insurer activities by the Superintendent required additional reviews of the differential itself. Unlike the 1982 statute which required the first Komaroff report, this statute was more explicit in its references to the differential in regard to State regulation of insurance. The Legislation directed the State Hospital Review and Planning Council (of which the Komaroff Committee was a part) to conduct its review in conjunction with the Subcommittee on Insurance of the Legislature's Council on Health-Care Financing. Furthermore, the new statute specifically called for the Subcommittee on Insurance to review the differential "with respect to, among other factors, the availability of health insurance . . ." The statutes are attached as Exhibit "J".

42. The 1988 statute made it clear that the differential's purpose was to regulate insurers and insurer activities in the health insurance markets. First, the 1988 statute was structured to provide incentives to both Blue Cross and commercial insurers to obtain a greater or lesser differential by undertaking specified

insurance enrollment activities designed to create broader access to health insurance. Secondly, the statute called for two reviews of the differential—both of which referred to the role of the differential in health insurance.

The Second SHRPC Komaroff Report

43. The Komaroff Committee was reconvened to conduct the State Hospital Review and Planning Council's second review of the differential. As occurred during the first review, the principal parties to the deliberations were commercial insurers, Blue Cross and Blue Shield Plans, the State Insurance Department and other payors of hospital bills.

44. The second Komaroff Committee report, a copy is attached as Exhibit "K", was issued in 1989.

45. The Committee's recommendation regarding the differential began by stating that:

> No concrete, absolute or precise information regarding the value of the differential is available, except of course in the area of prepayment. Although this is somewhat frustrating, it is not surprising since the differential is an indirect stimulus—not a direct stimulus—to fulfillment of various goals. Nevertheless, by a strong consensus, the Committee recommends that the existing differential should be continued in 1991 and for a reasonable period beyond that, unchanged in amount. The Committee believes that the differential provides some form of leverage in encouraging payors and hospital providers to engage in activities which accomplish public policy objectives. Based on our understandings, changes could further destabilize a hospital system already in considerable financial distress and therefore threaten the maintenance of quality patient care.

46. Most importantly, the recommendations acknowledged that the differential provides legislators and regulators with "some form of leverage" over insurers to encourage them "to engage in activities which accomplish public policy objectives." This is an explicit statement that the State uses the differential to control the insurers' business activities—which is the essence of a State's regulatory scheme for the insurance business.

The Report of the Subcommittee on Insurance

47. Later in 1989 the Subcommittee on Insurance of the Legislature's Council on Health Care Financing issued their report regarding the differential. Since the two reports were prepared in cooperation with each other, they recite the history of the differential and the policy analysis in a similar fashion. The Subcommittee on Insurance recommended that future use of the differential, and the level or amount of the differential, be guided by the following principles:

(a) The differential has served as a useful vehicle to promote social policy objectives, especially access to broad and affordable health care coverage, and should continue to be used as a vehicle—although not an exclusive vehicle—to achieve such objectives.

(b) The differential should be structured to encourage payors to adopt practices which broaden insurance coverage, and which promote hospital cost savings.

See Subcommittee Report at p. 5. A copy of the Report is attached as Exhibit "L".

48. The Subcommittee on Insurance concluded that the differential should be continued, in part because "the differential does provide leverage in encouraging payors and hospital providers to

engage in activities which accomplish public policy objectives." *See* Exhibit "L" at p. 6.

The Gottfried Insurance Underwriting Bill

49. In 1991, Assemblyman Richard N. Gottfried introduced a bill to increase the differential, but not on an across-the-board basis. The bill provided that the differential would be increased only for certain insurers which engaged in particular insurance underwriting practices which the Legislature desired to discourage. Specifically, the bill required insurers that utilized physical exams, laboratory or screening tests, such as for the HIV virus, to pay an extra 6% in their hospital reimbursement rates. Similarly, insurers which utilized industry or occupational classifications to determine premium rates or eligibility for coverage would also pay an extra 6% in their hospital reimbursement rates. A copy of the bill and explanatory material are attached as Exhibit "M".

50. The bill was subject to considerable debate but was not brought to a vote. Evidence of the underlying debate regarding the contrasting practices of commercial insurers and Blue Cross and Blue Shield Plans is displayed in the memoranda each party submitted to the Legislature regarding the bill. *See* Exhibit "M". This includes memorandum submitted by the Blue Cross and Blue Shield Plans documenting the number of customers they had lost due to the alleged "cherry-picking" by commercial insurers.

51. The bill is a clear example of further efforts to construct the hospital rate setting system in a fashion designed to induce insurers into abandoning objectionable practices or, in the alternative, compromising the financial advantages the insurer obtains from those objectionable practices and attempting to compensate for those practices.

52. The bill proposed that the funds from the underwriting allowance be used in the bad debt and charity care system already

in existence to help nospitals pay the costs of serving persons who have been rejected by insurers. This was the first time a bill proposed using differential funds for a particular purpose, rather than simply paying them to the hospitals.

Increasing the Differential to 24%

53. During 1991, a debate began regarding whether the differential should be increased above 13% and closer to the level which existed in the 1970's before the Legislature specified a differential in statute. The discussion was fueled by financial difficulties of Empire Blue Cross and Blue Shield caused in part by the loss of several hundred thousand good risk customers from Empire's community rated programs. *See* Affidavit of Jerry Weissman submitted herewith. Attached as Exhibit "N" is a copy of a letter sent by the Blue Cross lobbyists to legislative leaders alerting them to the problem and urging legislative action to solve the problem. Similar letters were sent to a variety of legislative leaders and the Governor's office.

54. The calls for an increase in the differential were in recognition of the fact that the skimming or cherry-picking by certain commercial insurers of the Blue Cross Plans' good risk groups had greatly accelerated in the late 1980's and early 1990's. When an insurer can avoid 30% or more of average health care costs through the use of medical testing and rejecting applicants who have a history of needing medical care, the insurer can obtain a competitive advantage that more than offsets the 13% differential. This "cherry-picking" occurs frequently today due to the use of sophisticated blood tests (such as HIV testing) as well as commercial insurers longstanding refusal to issue coverage to certain industries. In order to restore a level playing field, the Legislature determined that the differential would have to be increased in order to be commensurate with the competitive advantage obtained from selective underwriting practices.

55. For example, over the last six years, Empire has lost more than 500,000 of its good risk small group customers, roughly half of its community pools. In 1986, Empire had a ratio of good risks to poor risks in the small group pool of 10:1. By 1991, the ratio was only 3:1 because of the cherry-picking.

56. When the good risks (those having health care costs lower than average) are cherry-picked out of the Blue Cross community pools by virtue of the commercial insurer risk selection and marketing practices, it has a significant impact on premiums, since the average cost of insuring persons with higher than normal health care costs must necessarily rise to reflect the loss of persons whose costs were less than average. This results in increased premium rates. This creates a spiraling effect where the Blue Cross premiums rise and the remaining good risk groups covered by Blue Cross are again lured away, thus necessitating another rate increase for Blue Cross' remaining subscribers. From the public's perspective, health insurance becomes more and more unaffordable.

1991 Legislative Hearings

57. In 1991, the State Assembly Insurance and Small Business Committees held a joint hearing to consider proposals for health insurance reform. Early in 1991, the Governor had introduced a bill to reform the health insurance process for small groups and individuals so that no insurer could blacklist industries or reject applicants due to their health status. Since such a bill would force commercial insurers to behave in some ways the same as Blue Cross and Blue Shield, the question was raised whether the differential should be increased as well (as Blue Cross suggested) or be eliminated (as the commercial insurers suggested).

58. The testimony of the Superintendent of Insurance before the Assembly Committee is attached as Exhibit "O". On pages 13-14, the Superintendent pointed out the contrasting positions

regarding whether the differential is sufficient compensation to Blue Cross for its less restrictive insurance underwriting practices and community rating method of establishing premium rates. The Superintendent clearly articulated the linkage between the differential and the insurance marketplace. All parties clearly viewed the differential as compensation for the unique Blue Cross underwriting activities. The only dispute was whether 13% was adequate compensation. In a subsequent portion of the hearing, the Superintendent and Assemblyman Lasher, the Chair of the Assembly Insurance Committee, engaged in an extended dialogue regarding the variety of instances where Blue Cross performs different insurance related services, or is regulated by the Insurance Department, in a different fashion than commercial insurers (pages 27-35).

The 1992 Legislative Efforts To Increase the Differential—The 1992 State Budget.

60. In January of 1992, the Governor submitted his proposed budget for the State's fiscal year which was to begin in April of 1992. The budget contained two provisions to reform the health insurance market. First, an increase in the differential to 25%, the level of the differential during the 1970s and early 1980s. Secondly, the Budget sought the enactment of the underwriting and premium-setting reforms the Governor had proposed in 1991.

61. As discussions progressed regarding the proposal to increase the differential, questions arose regarding the use of the funds which would be generated by the differential. Traditionally, the monies from the differential were paid to the hospitals as part of the hospitals' rate, and the hospitals retained the monies as compensation for rendering services. Beginning in 1991, the hospitals had received over $450 million in new revenues as a result of other legislative changes in the hospital rate-setting system. *See* Public Health Law §2807-c(1)(e)(iii). Department of Health officials, therefore, stated that they did not want any

additional differential monies to remain with the hospitals. A program providing free health insurance to young children without health insurance, for which funding was inadequate, was considered as a recipient of the new monies. This proposal was similar to the Gottfried underwriting allowance bill which had proposed using the funds from the underwriting allowance differential to pay for care by persons rejected by insurers. Eventually, it was decided to turn the money over to the State Treasury to help close the State's enormous budget gap.

1992 Legislative Hearings

62. In March 1992, as the Legislature was well into its budget negotiations, the State Senate Insurance Committee held a hearing to discuss the Governor's reform proposals. A copy of the testimony provided by the Superintendent of Insurance is attached as Exhibit "P". The Superintendent explained the insurance underwriting process and what he perceived as the drawbacks to that process. On pages 6 and 7, he pointed out that commercial insurers believed the 13% differential is ample compensation to Blue Cross for its socially desirable underwriting practices, while Blue Cross believed the 13% differential is not sufficient. The Superintendent made a further reference to the differential when he noted that the Governor's bill required HMOs to make their coverage available on an open enrollment basis. He explicitly stated that HMOs have benefited from the differential but have not performed the community service of open enrollment, and the Governor's bill "would correct this inequity." *See* Exhibit "P" at p. 11.

63. In summarizing his testimony, the Superintendent stated:

> "When one carrier assumes the social responsibility of insuring all those that the others reject, it is becoming clearer that the current hospital differential and favorable

tax treatment are insufficient to offset the costs associated with accepting poorer risks."

See Exhibit "P" at p. 14.

April 1, 1992 Opinion and Decision on Rate Increases

64. Coinciding with the legislative events described above was the proposed April 1, 1992 effective date of a rate increase application submitted by Empire Blue Cross and Blue Shield to the Superintendent. The Superintendent granted a two part rate increase, specifically stating that he would rescind the second part if the Legislature enacted sufficient reforms. The Superintendent stated that passage of the Governor's bill "which contains provisions to require community rating and open enrollment, coupled with a change to the hospital reimbursement rates paid by commercial insurers, will provide the framework for Empire's long-term financial recovery by creating a more equitable playing field and correcting prior imbalances." *See* page 12 of the Opinion and Decision from April 1, 1992, attached as Exhibit "Q". In July of 1992, the second part of the rate increase was rescinded by the Superintendent.

The Final Result

65. Following extensive negotiations with the Legislature, the differential was increased by an additional 11% (total differential—24%) for commercial insurers in the April 1992 Budget bill, a copy of which is attached hereto as Exhibit "R". Other parties subject to the 13% differential (no-fault auto insurers, workers' compensation programs, volunteer ambulance and firefighter programs and self-insured plans, etc.) remained at the 13% level and were not subject to the extra 11%. The differential was increased only for the period from April 1, 1992 to March 31, 1993, the State's fiscal year.

66. The proposed reforms of the insurance underwriting and premium-setting process were separated from the budget negotiations. However, three months later the Legislature passed, and the Governor signed, Chapter 501 of the Laws of 1992 which implemented those reforms.

Veto Message of July 24, 1992

67. After the differential was increased to 24% effective April 1, 1992, further legislation was introduced which sought to require commercial insurers to pay the additional 11% directly to the State, rather than for the insurers to pay the hospitals and then have the hospitals remit the funds to the State which is the present method of payment. The Governor vetoed this bill. *See* attached Exhibit "S" for a copy of Veto Message #14. The veto occurred for other reasons, but it is important to note that the Governor commented in the veto message that one of the reasons the differential was increased to 24% was to provide "competitive support for Blue Cross, which serves higher risk residents."

D. CONCLUSION

66. A review of all the materials above compels the conclusion that for over 30 years the differential has been the State's primary tool to encourage insurers to engage in socially desirable practices of issuing health insurance on an open enrollment basis and determining premium rates on a community rating basis. In other words, the differential has been used as an incentives to insurers in an attempt to manipulate insurer practices so that insurance products would be delivered to the insurance buying public in a fashion which facilitates public health and insurance policy. These efforts are the heart of the State's long-term effort to regulate insurer behavior and the business of health insurance in order to attain the State's policy goal of broad availability of health insurance at affordable rates.

67. All other aspects of the differential have been ancillary to the efforts to regulate insurance. The hospitals do receive revenues from the differential paid by commercial insurers and other payors. Part of the justification for the differential is the savings or convenience which Blue Cross provides to hospitals. And beginning in 1992, the revenues from the extra 11% differential were diverted from hospital coffers to the State Treasury. Which party is the beneficiary of the differential payments has never constituted the primary goal or purpose of the differential. From the Trussell Report in 1958 to the Governor's Veto Message in July 1992, the long-standing, recurrent theme of the differential has been to regulate insurers and their marketplace so that the State could attain its public policy goal of opening insurers' doors to those who otherwise would likely not be able to obtain health insurance.

ALBERT F. ANTONINI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Daniel Sisto, filed October 2, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Daniel Sisto, being duly sworn, deposes and says:

1. I am President of the Intervenor Hospital Association of New York State ("HANYS"). In this position, I am familiar with the operation and circumstances of hospitals throughout New York State and have an intimate knowledge of the State's hospital reimbursement system. I have been involved, in one position or another, in hospital care and its financing for over 15 years and therefore am familiar with the evolution of our hopsital reimbursement system over the past several years.

HANYS is a not-for-profit trade association whose membership includes over 240 general hospitals, all of which are not-for-profit, voluntary or public providers of hospital services in New York State. HANYS provides technical, administrative, legal, and lobbying services on behalf of its members, and regularly interacts with legislative and executive branch officials over existing and proposed legislation. HANYS also follows health care activities, including hospital reimbursement initiatives throughout the country. As a result of my affiliation with HANYS, therefore, I have personal knowledge of the matters related in this affidavit.

2. This affidavit is submitted in support of HANYS' cross-motion for summary judgment and in opposition to the plaintiffs' motions for summary judgment which are pending before this Court.

The position of HANYS in these litigations is to defend the legality of the 13% differential contained in Public Health Law section 2407-c(1)(b). The hospitals take no position on the 11% tax enacted this year as sections 348 and 349 of Chapter 55 of New York's Laws of 1992. The reason for this dichotomy is the significant and historical difference between the 13% differential and the 11% tax. As explained below, the 13% differential has been, in one form or another, a major component of the integrated, all-payor reimbursement system that has developed over a span of 14 years. The 11% tax, on the other hand, is a recently-enacted legislative measure designed to raise revenues for the State.

Under the statutory scheme in sections 348 and 349, the 11% add-on to payments made by commercial insurers is passed through to the State's general fund. A copy of these sections is annexed hereto as Exhibit A. Thus, hospitals derive no benefit, and in fact incur losses, under this statutory scheme. The 11%, therefore, is simply a tax on commercial insurers. At present, under a preliminary injunction in another action, the State is enjoined from requiring hospitals to pay the 11% estimated payments over to the State.

This scheme, as explained below, is in sharp contrast to the 13% differential, which has always been an integral component of the hospital reimbursement system. For this reason, the hospitals, through HANYS, are supporting the legality of the 13% differential, but are taking no position on the 11% differential.

3. In this affidavit, I will therefore describe the background of the 13% reimbursement differential (the "differential"), the reimbursement system now extant in New York and the place of the differential in the system, the importance of the differential in the financing and operation of hospitals, and the implications of voiding the differential. As the Court will see, plaintiffs are not really attacking a unique element of a reimbursement system that unfairly impacts on employee benefit plans. Rather what plaintiffs are actually challenging is the right of the Legislature to establish a comprehensive reimbursement system that determines the reimbursement rates for all payors.

HISTORY OF THE DIFFERENTIAL

4. Plaintiffs in this action have neglected to describe why and how the differential was established and instead have portrayed this feature as an additional and unfair fee levied against them. On the contrary, the 13% differential has evolved from circumstances which the commercial insurers and others found intolerable and has its roots in attempts to alleviate commercial insurers' concerns.

5. During the 1970's, payments for hospital services, particularly for patients insured by commercial insurance, were largely unregulated. Commercial insurers were billed for services to the insureds based upon the hospital's charges, which were set on a hospital-by-hospital basis, without a limit. From the mid-70's, commercial insurers and others complained that hospitals' charges had escalated dramatically and disproportionately. As a result, Chapter 517 of the Laws of 1978 was enacted. This statute froze hospital charges at May 1, 1978 levels. As of January 1, 1979, charges could only increase based on an inflation formula which, according to the statute, would be developed by an independent panel of expert economists.

6. When the legislation which became Chapter 517 was awaiting the Governor's signature, the Division of the Budget observed; "This bill will help control the escalating cost of hospital

charges to private patients and patients covered by commercial insurance carriers." In addition, the Budget Division also said; "This bill is an important step toward a uniform system of hospital reimbursement which should keep hospital costs at a reasonable level, eliminate subsidization of one type of payor by another, and reduce the administrative complexities of the current system." The Budget Division's memorandum is attached as Exhibit "B."

7. At the same time, the State Insurance Department observed (see Exhibit C annexed hereto):

> This legislation also "freezes" the hospital's regular charges established for in-patient services for all persons utilizing such services at the level of charges in affect May 1, 1978 (except in the case of a successful appeal). This will prevent hospitals from increasing charges at an uncontrolled rate and also protect those payors not currently included in the cost containment mechanism from being unfairly and inequitably charged for hospital services because no controls exist as to such payors."

8. There was recognition at that time that the charge control and other features of Chapter 517 were not sufficient to establish a uniform and comprehensive reimbursement system. The Governor, on approving Chapter 517, stated that "[t]hree of the bills . . . provide a reasonable approach to the containment of hospital costs during the period of time needed to develop the uniform system of hospital reimbursement which I have advocated." (Governor's Approval Memorandum on Chapters 517, 518, 519 and 520 of 1978, dated July 25, 1978; Exhibit "D.")

9. Enacted along with the charge control law was Chapter 520 of the Laws of 1978, which established the Council on Health Care Financing. The Council was charged with the responsibility of proposing a new system for financing general hospital inpatient care. It was required to issue a report by the end of 1979 and from that report, it was anticipated, would emanate legislation to establish a uniform reimbursement system.

10. The Council on Health Care Financing, pursuant to Chapter 520 of the Laws of 1978, consisted of a broad array of representatives of state government, the hospital industry, and various payors, including the commercial insurers. The Council issued its first report in October 1980 and addressed, among other things, the issue of charges for commercial insurers, as well as the difference in rates paid between commercial insurers and others, such as Blue Cross. Certain insurers, such as Blue Cross plans, did not pay hospitals based upon their charges, but rather based upon the hospitals' costs, which were significantly lower. Even with the freezing of charges in 1978, the Council recognized that the difference between cost-based payments and hospital charges did not provide for an equitable reimbursement scheme. This problem had persisted because charges had been frozen at levels which were widely disparate. Each hospital had been free to establish its own charge levels, so that charge levels varied hospital by hospital, with no uniformity.

11. Based on data available at the time, the Council report indicated that hopsital charges ranged from a low of 113% of cost-based payments, to a high of 136%, with the average at approximately 125%. With the objective of establishing a reasonable payment differential, the Council recommended a flat uniform differential rate which was below the lowest charge level of any hospital at the time. Relevant portions of the Council's 1980 report are attached as Exhibit "E."

12. Nearly two years elapsed from the Council's 1980 report and the enactment of Chapter 536 of the Laws of 1982, the first comprehensive uniform reimbursement legislation. Chapter 536 enacted Public Health Law §2807-a (renumbered in 1987 as Public Health Law §2808-c) to govern payments to hospitals by

all payors: Medicaid, Blue Cross plans, commercial insurance, self-pay patients, health maintenance organizations, workers' compensation, no-fault, and even the federal Medicare payment system. The text of Chapter 536 reflected certain changes which had been negotiated from the time of the Council report until the enactment of the law.

Subdivision 13 of then §2807-a provided that, during 1983, charges would continue to be frozen and subject to adjustment only for inflationary purposes as dictated by the independent panel of economists. Subdivision 6 of that section provided that for the years 1984 and 1985, charges would be limited to three categories: if a hospital's average charges were no more than 12% higher than the cost-based rate, then charges could not, for that period, exceed 12% of the cost rate; if charges were between 12% and 15% above the cost rate, they could remain at those levels, and within that corridor; if charges exceeded 15% of the cost-based rate (which the Council had observed two years earlier would have been the case with most hospitals), then charges would have to be reduced so as not to exceed 15%.

Thus, the "differential" was first statutorily established as a direct state cost control measure on hospitals, limiting their ability to charge commercial and other charge payors widely varying and excessive amounts. It became an integral piece of the first state comprehensive "all-payor" reimbursement system. The differential, therefore, was not an add-on to hospital rates to be paid by commercial insurers; it was a limitation on the amount commercial insurers could be charged.

13. The purpose of the differential was expressed by the Division of the Budget, which stated (see Exhibit F annexed hereto):

> Due to the fiscal constraints . . . self-pay patients and commercial insurers were required to shoulder much of the burden of financing costs not reimbursed by other

> payors. Even with existing charge control limitations, self-pay patients and commercial carriers argued that an unreasonable proportion of costs were incorporated in their charges for services. With enactment of this legislation, uncompensated liabilities will be more equitably distributed to all payor sources (i.e., through the Bad Debt and Charity Care Fund) and self-pay and commercial charges will be more reflective of the actual cost of providing services.

14. In view of the purpose of this legislation, it is not surprising that it was supported by the commercial insurance industry. Significantly, the Health Insurance Association of America, one of the plaintiffs in these actions, wrote to then Governor Carey expressing its "strong support" for the legislation and urged the Governor's approval. The letter from HIAA (annexed as Exhibit "G" stated in part:

> For more than a decade, the health insurance industry has expressed growing concern not only over the drastic rise in health care costs nationwide, but also with the fragmented, arbitrary and unfair health care reimbursement practices in New York State. We have advocated establishment of a uniform prospective reimbursement system based on a definition of hospital full financial requirements that would meet hospital financial needs and was fair to all third party payors.

15. Thus, the differential served two purposes. First, it more severly limited the amount charge payors, including commercial insurers, would have to pay for hospital services. Second, it was a key element in the development of a uniform, comprehensive prospective reimbursement methodology which encompassed all payors of hospital care. The Plaintiff HIAA endorsed both concepts.

16. The inpatient reimbursement system enacted in 1982 was, and still is, commonly referred to as the New York Prospective Hospital Reimbursement Methodology ("NYPHRM"). The provisions enacted in 1982, known as "NYPHRM I," were by their own terms to last for three years, 1983 through 1985.

17. In 1985, the Legislature enacted NYPHRM II by Chapter 807 of the Laws of 1985. Chapter 807 renumbered the old Public Health Law §2807-a as P.H.L. §2808-c, and inserted a new §2807-a. This statute completed the transition from a fragmented charge system to a uniform charge system. In subdivision 12 of the new §2807-a, charges were not to be more than 12% higher than the Blue Cross rate. Variations were no longer permitted and uniformity had been reached.

18. When the legislation which was to become NYPHRM II was awaiting gubernatorial action, Plaintiff HIAA again wrote to the Governor to urge approval. (See Exhibit "H"). HIAA did address the differential, recommending that differentials be based on objective standards. Notably, HIAA did not question the validity of a differential, but simply expressed the desirability of further inquiry into lowering it. Similar views were also expressed to the Governor's office by the Metropolitan Life Insurance Company. (Exhibit "I"). Again, therefore, the uniform 12% differential established in 1985 addressed in part the concerns of the commercial insurance industry for a uniform and lower differential. Those amendments to NYPHRM continued to be supported by the commercial insurance industry generally, and HIAA specifically.

19. NYPHRM II governed inpatient reimbursement for the years 1986 and 1987. As had occurred in the past, a bill was passed by the Legislature in 1987 which would have governed reimbursement as of January 1, 1988. The NYPHRM III bill contained a uniform 13% differential. HIAA again wrote to the Governor, expressing its support for the NYPHRM III bill and

urging the Governor not to veto it. (HIAA's letter of July 10, 1987 is attached as Exhibit "J"). HIAA also sought the implementation of a "case payment" system for all payors, including commercial insurers.

20. There was considerable opposition to a number of features of the proposed NYPHRM III. A major issue that developed was what reimbursement system would be in place if the NYPHRM III bill were vetoed. It was recognized that with the expiration of NYPHRM II on December 31, 1987, and no new system created in its place, the State control over rates paid by commercial insurers would dissolve. This was of major concern to commercial insurers, including HIAA, which wrote that, "a veto of this proposal would result in a legislative framework devoid of effective charge control and open to the unabated cost shifting which occurred prior to NYPHRM." (Exhibit J). The prospect of a return to pre-NYPHRM times was anathema to the commercial insurers.

21. Attached to the HIAA letter of July 10, 1987 was a series of suggested improvements for a NYPHRM III system. On the question of a differential, HIAA suggested that a series of differentials be enacted. HIAA did not assert that any differential would be preempted by ERISA or otherwise illegal. HIAA merely requested that the issue of the size of the differential be further studied by the Council on Health Care Financing's Subcommittee on Insurance.

22. Governor Cuomo vetoed the July 1987 legislation for reasons unrelated to the differential. It was only in January 1988 (Chapter 2 of the Laws of 1988) that the NYPHRM III law was enacted, containing an across-the-board 13% differential. The law also provided for exactly what HIAA had requested, a charge to the Subcommittee on Insurance to study and report on the differential issue. (L. of 1988, Ch. 2, §21).

23. The Subcommittee, in which HIAA participated, issued its report on March 31, 1989. The report reviewed all previous studies and examined insurance industry practices. The report recommended retention of the differential, with its application linked to insurers' practices. (The Subcommittee report is attached as Exhibit "K").

24. In 1990, the current system, NYPHRM IV, was enacted as Chapter 907, to govern reimbursement from 1991 through 1993. Consistent with the Subcommittee report, which HIAA had sought and in which it had participated, NYPHRM IV maintains the 13% differential. (P.H.L. §2807 c[1][b]). This is the differential Plaintiffs now challenge. It is the same differential that, in slightly differing amounts and form, existed since 1982 and was supported by the commercial insurance industry, particularly Plaintiff HIAA.

THE HOSPITAL REIMBURSEMENT SYSTEM

25. With the enactment of NYPHRM III in 1988, a case payment system was established for most patients, based on diagnostic related groups (DRGs). This is a payment technique implemented by the federal government for the Medicare system in the early 1980's. It was replicated in the NYPHRM system as a cost control measure and had been advocated for by HIAA (Exhibit "J"). Current P.H.L. §2807-c, which governs the in-patient hospital reimbursement methodology for all payors, is a lengthy and complex statute. One component of this statute, found in section 2807-c(1)(b), provides that commercial insurers and self-insured funds which provide reimbursement on an expense incurred basis (as well as Workers' Compensation, No-Fault and a host of other payors) pay a rate based on the applicable DRG, but which includes the 13% differential.

26. As noted above, the differential payment is an integral piece in the overall reimbursement system which has existed in

New York State for a decade. It is only one of many adjustments made to a DRG rate to arrive at a particular payor's reimbursement rate for hospital servies to its insureds. Plaintiffs now single out this individual component of the methodology as objectionable, challenging on ERISA preemption grounds a feature of the system that they supported since 1982.

27. Plaintiffs' tactics are problematic for at least two reasons. First, because the reimbursement methodology is integrated, the disruption of certain portions such as the differential necessarily would affect the entire system. Second, plaintiffs' approach is riddled with inconsistency in that there are numerous other features of the system which also apply to self-insured and commercially insured plans, but which have gone unmentioned.

28. The reimbursement methodology found in section 2807-c of the Public Health Law is intended to accomplish several objectives. First, it is intended to provide hospitals with the financial resources that are reasonable and adequate to meet the costs of an efficiently and effectively operated facility. Second, it is intended to distribute those costs equitably among all payors. Third, it is intended to meet the needs of all patients for hospital services, regardless of their source of payment, if any. Fourth, it is intended to provide a measure of stability and predictability, so that hospitals can budget and plan for the development of new services, the acquisition of new equipment or the renovation or new construction needs of the hospital. Fifth, it is intended to maintain open access to hospital services.

The integrated all-payor reimbursement system reflects the realities of the system of providing hospital care. Hospitals exist to serve entire communities, not isolated subgroups in the communities. Over the course of time, all types of patients will need hospital care, and they will need different levels of resources. In order to meet these demands, a hospital must be fully staffed and equipped at all times. The reimbursement system responds to this

community need by providing for payment levels which allow for the staffing to be maintained even though, for example, on a particular Tuesday a particular patient may not need all the resources which are otherwise available. The reimbursement system incorporates the various needs of different patient classes and then establishes, in general, appropriate rates which must be paid in order for those patients to be served. If, however, a certain payor class refuses to participate in the system as it is constructed, the hospital as an operating entity is threatened. When a hospital is threatened, all patients, including those patients whose payors are refusing to participate in the system, are deprived of the access to and quality of care which they now receive.

29. The "integration" of the hospital financing system is accomplished in a variety of ways. The basic feature of our current system is the use of DRGs. The DRG system pays a hospital an amount depending on the patient's condition, regardless of how long the patient is hospitalized. The general concept behind DRGs is that a patient with a particular condition requires a particular level of resources to be treated appropriately. While the "basic" DRG is designed to be sensitive to individual patient resource consumption, the rate-setting process, and by extension the entire reimbursement system, necessarily accounts for other phenomena which are not all traced to individual cases. The method for accounting for these phenomena is a series of adjustments which are applied to arrive at *all payors'* rates.

30. The current payment system uses 1981 as a "base year" for determining the costs of care. The 1981 base costs are "trended," *i.e.*, generally adjusted for inflation, to the rate year, the year in which a rate is to be paid. The initial trending of base year costs, on its own, however, results in a skewed profile of costs since not all costs have moved in a uniform pattern consistent with general inflationary trends.

31. For each rate year, a "trend factor," *i.e.*, the inflation adjustment, is set using projected estimates. Subsequently, the projected trend is further adjusted using actual economic data. For example, the "trend" portion of 1992 rates consists of projected 1992 inflation, and adjustments for 1990 and 1991 estimated trends now adjusted to actual. The recalculation of prior years' trend factors and the setting of the upcoming year's estimated trend is an annual event.

After trending, there are scores of adjustments and calculations made, for all payors, to arrive at a particular year's rate. The calculations to derive a rate are complex and lengthy. Each hospital at the beginning of a rate year, is issued a "rate sheet" describing the calculations for that hospital. Currently, a typical hospital "rate sheet" is an inch-thick document of tables, calculations and adjustments. Among the adjustments are the following:

a) Adjustments due to a hospital's successful prosecution of an appeal of its rate level for a prior year. (P.H.L. §2807-c[9][b]). Since each year's rate in part depends on a prior year's rate, altering the latter necessarily alters the former. It may take two years from the close of a rate year before an appeal is finally decided, so that the disposition of just one appeal has a multi-year, cumulative impact. On average, about 1,800 appeals are filed each year by all hospitals;

b) A volume adjustment which adjusts the costs upon which a rate is based, depending on whether the total volume of patients entering the hospital increased or decreased beyond a certain threshold in the prior year (P.H.L. §2807-c[9][f]);

c) Special adjustments for teaching hospitals, which are hospitals which have medical residence programs. Beginning in 1992, these adjustments were further refined depending on the type program, *i.e.*, primary care or specialty, and the number of students. (P.H.L. §2807-c[25]);

d) Adjustment for "rural" hospitals, depending on location. (P.H.L. §2807-c[4][f]);

e) An adjustment to eliminate the hospital's cost for treating Medicare patients, since Medicare is a federal program and the state system governs only reimbursement for all non-Medicare patients (P.H.L. §2807-c[11][g]);

f) A calculation of the amount of charity care and bad debts experienced by hospitals and mechanism for partial and redistributive payments for such charity care and bad depts. (P.H.L. §2807 [14, 14-a, and 14-c]);

g) A "case mix" adjustment to account for an increase in the overall severity of hospitalized patients' conditions from year to year. (P.H.L. §2807-c[11][f]). The case mix adjustment is subject to a limit which will be described more fully below;

h) Various adjustments for "inlier" and "outlier" cases, which refer to patients whose stays at the hospital are extraordinarily long, short, or costly. (P.H.L. §2807-c[4][b]-[d]);

i) An "ALC" adjustment. (P.H.L. §2807-c[4][h]). Patients who remain hospitalized usually awaiting nursing home placement and who are receiving nursing-home level care at the hospital are referred to as alternate level of care, or "ALC" patients. This adjustment carves out a hospital's ALC costs, because these costs are reimbursed under a different methodology;

j) A variety of adjustments for so-called "enhancements" to rates, discussed further below, to reflect the unusually rapid cost increases in nursing and other professions' salaries, malpractice insurance, waste removal, infection control supplies (gloves, gowns, etc.) and other items. (P.H.L. §2807-c[1][e]);

k) Adjustments for a hospital's capital expenses. (P.H.L §2807-c[8]); and

l) An adjustment to generate funds supporting primary care initiatives in underserved areas. (P.H.L. §2807-c[14-b]).

32. The purpose of listing some of the numerous adjustments made to each hospital's base rate is to illustrate the steps leading to the rate which is used. After the above and other adjustments are made for each hospital, further calculations are made. Each hospital is grouped with a number of peer facilities which share certain characteristics. The hospitals' costs, calculated as described above, are averaged to arrive at a "group average" price. (P.H.L. §2807-c[7]). The rate which is finally issued for a hospital is a blend; 55% is the group average and 45% is the hospital's specific cost. (P.H.L. §2807-c[5][b][iii]).

33. These various adjustments and all payors' rate are interdependent and take into account the differential and the payors whose rates include the differential (commercial insurers, self-insured plans, Worker's Compensation, No-Fault and others). The process ultimately relies on all patients' needs for hospital care and participation by all payors.

34. I should emphasize that the rate promulgation process is applicable to all non-Medicare payors. For example, there is no exemption from one calculation for certain payors. This is so because the rate making process is an attempt to allocate both patient-specific and more generalized costs among all users and payors of hospital care.

35. The current reimbursement system, as stated above, is a complex statute with a variety of features. Plaintiffs have chosen and easily identifiable portion to attack, while ignoring many others. For example, in addition to the various adjustments and calculations described above, the current NYPHRM system con-

tains many "enhancements." Subdivision[1][e] of §2807-c provides for hundreds of millions of dollars to be added to reimbursement rates, in the aggregate, to reflect increased nursing salaries and other labor costs, the cost of malpractice insurance, waste disposal costs and other items whose costs have increased far above normal inflationary factors. These enhancements have been built into the system, i.e., into all payors' payment rates, to recognize that without these funds to support these services and demands, hospitals would be unable to provide care. Yet, Plaintiffs are silent as to these items. These enhancements and the previously-described adjustments affect or relate to ERISA plans no differently than the 13% differential, or even the DRG system itself. Many other examples exist.

36. Subdivision 3 of P.H.L §2807-c is a detailed statutory framework for establishing the diagnosis related groups and the "weights" which are assigned to these groups in order to ascertain appropriate reimbursement rates. These provisions are fundamental to a DRG payment system, and yet Plaintiffs fail to comment on the propriety of the methodology which directly determines what rates a plan or any other payor pays.

37. In addition, Plaintiffs notably do not challenge the provision in subdivision 11(e) which provides that if a bill is paid within 10 day of its receipt, the payor may reduce its payment by 2%. Apparently, Plaintiffs are satisfied to retain this portion of the statute, making no claim that the item which saves the Plaintiffs some money is preempted by ERISA.

38. Similarly, in paragraph (f) of subdivision 11, there are extensive provisions that limit so-called case mix increases. These are payment increases which result from two phenomena; the increase in intensity of patient needs (increases in the number of sicker patients who use more resources), and so-called case mix "creep," which is an increase in billings due to billing coding practices. The statute caps the amount by which rates may

rise due to case mix increases and virtually eliminates any possibility of case mix creep, thus regulating what would otherwise be payment increases. The Plaintiffs have no complaint with this provision of the statute and yet it certainly affects ERISA plans as much as the differential.

IMPORTANCE OF THE DIFFERENTIAL TO HOSPITALS

39. As described above, the differential has been a constant statutory feature of the reimbursement system for a decade. It is a component of rates paid, not only by commercial insurers and self-insured plans, but also by a host of other payors for hospital services rendered. The differential is income to hospitals to offset the costs of providing services to patients. As operating income for ten years, the differential plays a fundamental role in hospitals' planning, budgeting and delivering of service. Across the hospital system, it is not a paltry sum: currently the 13% differential from all payors provides about $160 million in operating income annually to hospitals statewide.

40. This income is not newly created. The differential has been a steady and necessary source of financial support for hospital services. Indeed, the abrupt termination of this support would cause havoc with hospitals' ability to continue services at their present levels. Budgeting for ongoing operations or new initiatives would immediately be jeopardized, with a resultant diminution of access to and quality of the hospital care now being provided.

41. The differential has been incorporated into all hospitals' revenue estimates because it is an integral feature of the rates paid for services rendered. The revenue, in fact, has been used to pay nurses salaries, make capital improvements, purchase needed equipment, open clinics and support the myriad of activities which constitute the operation of a hospital. The historic stability and predictability of this revenue has caused it to be routinely

budgeted and utilized for several years. As a result, hospitals anticipate the continued availability of this operating income.

The financial picture of hospitals throughout this state is bleak. Most hospitals have been experiencing operating losses for several years, and of the few that have been operating profitably, the positive margin is razor thin. Further losses may lead to serious reductions in services.

42. The removal of the revenues from the differential will undoubtedly affect services. Hospitals services are provided not for the hospitals' benefit, but for all patients' benefit, including patients with commercial or self-insured plan coverage. Thus, the ultimate impact of a revenue loss of this magnitude will be felt by all patients.

IMPLICATIONS OF VOIDING THE DIFFERENTIAL

A. *Lack of Uniformity*

43. The plaintiffs' attempts to characterize elimination of the differential as a means to achieve payment uniformity are fallacious and misleading. Nationally, there is only one "uniform" hospital reimbursement scheme, i.e., the federal Medicare program which insures the elderly and certain disabled individuals. As to rates paid by commercial insurers and self-insured plans, no uniform model exists. Rather, each state, like New York, has established its own payment system, and each state's system and rates are different.

For example, a variety of states have all-payors systems, while others do not. Some states provide for cost-based reimbursement, while other states have charge-based or a DRG-based system. In many states, rates are simply negotiated between the hospitals and certain payors, without statutory controls. Thus, not only are

the rate methodologies entirely different is each state, but different hospitals have different rates within each state.

44. Eliminating the differential will not make New York's system "uniform" with the other states. It would simply make New York different is a different way. Each state has its own unique system; with or without the differential, there will continue to be 50 different payment systems and New York's would continue as a unique system. Elimination of the differential has nothing to do with nationwide uniformity. Within New York State, should the plaintiffs prevail, the present level of uniformity would actually be destroyed.

45. The essence of the present dispute is whether the State may mandate the components of a rate to be paid by employee benefit plans, together with all other payors. Should the Plaintiffs prevail, the State's authority to set plans' rates would be invalidated. The result would be an unregulated "system" in which each hospital would set its own rate for employee benefit plans. Where there is now uniform rate regulation, there would instead be *ad hoc* rate charging by the some 270 hospitals in the State. To characterize this outcome as "uniform" is patently ridiculous. This is exactly the chaos lobbied against by HIAA when it fought the veto of NYPHRM III. (See paragraph 19 above and Exhibit J annex hereto). While Plaintiffs have exhorted the catchphrase "uniformity" for its ERISA arguments, they have not referred to a single aspect by which reimbursement systems or rates are uniform anywhere in the country.

B. *Destruction of the Comprehensive System*

46. I have described that loss of the $160 million in operating revenue attributable to the 13% differential would be devastating to hospitals and patients. (paras. 39-42). The further effects of striking down the differential also merit description.

47. The differential is inextricably linked to the setting of plans' rates, and the setting of *all* payors' rates in an interrelated process. Not only would voiding of the differential lead to uncontrolled rates paid by ERISA plans, but it would substantially influence all other payors' rates to an extent which can be described, but candidly is not quantifiable.

48. As I described above (para. 25-38), the State's hospital reimbursement system is "integrated" *i.e.*, all payors' rates are set by allocating among all payors the costs of operating all hospitals. The system of allocation is in recognition of the fact that the patients covered by all payors rely on hospitals for their care. The balance among payors responsibilities for support of the hospital system is only maintained if all payors participate. Instability in one sector necessarily influences the others since each component, *i.e.*, each payor, is integral to the operation of the hospital system as a whole. We may assume that maintaining a viable hospital system is a reasonable goal which is not to be abandoned. If so, then for the "whole" to remain while one component has effectively withdrawn leaves the remaining payors (and their rates) to maintain the balance.

49. The reallocation of the hundreds of intricate adjustments, weights, limits, additions, exceptions and cost accounting procedures in the wake of uncontrolled commercial payments would be nothing short of chaotic. The chaos of which I speak is not bureaucratic chaos. It is the real-world day-to-day ability of each hospital to project its income and maintain costs within that level. The task would require a fundamental restructuring of each hospital's financial profile with a concomitant re-examination of patient care expenses and costs allocations.

50. The disruption in the ability of hospitals to maintain their viability and services would be widespread. The hospital financing system has evolved from an *ad hoc* unintegrated model to a comprehensive all payor structure, in an attempt to accommodate

all patients' changing health care needs. Patients' needs would be ill-served if we returned to the result advocated by the plaintiffs.

51. I understand that one of HANYS' affirmative defenses is the doctrine of laches, which involves unreasonable delay and prejudice. The delay in challenging the 13% differential is unreasonable, since a differential has existed in the law since 1982. Further, it was instituted for the benefit of commercial insurers, to limit the charges they would have to pay, and to establish uniformity. Plaintiff HIAA itself repeatedly lobbied in favor of these differentials.

The damage to the integrated all-payor system generally, and hospitals particularly, from the invalidation of the 13% differential would be tremendous and extremely prejudicial. Since the 13% differential relates to ERISA plans no differently than any of the myriad of other adjustments, enhancements and components of the reimbursements system, Plaintiffs are really challenging the right of a state to establish a hospital reimbursement system that applies to all payors, including employee benefit plans. The undue delay and prejudice from such a late challenge is indisputable, since this uniformity has been the structure around which all reimbursement legislation has been built since NYPHRM I.

For the foregoing reasons, I respectfully urge that the Plaintiffs' request for summary judgment be denied and that HANYS' cross-motion for summary judgment be granted.

DANIEL SISTO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Kathryn Allen, filed October 20, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Kathryn Allen, being duly sworn, deposes and says:

1. I am the Executive Director of the New York State Health Maintenance Organization Conference and make this affidavit in support of the motion for summary judgment submitted by plaintiff Health Insurance Association of America, *et al.* and in opposition to defendant's cross motion for summary judgment.

2. The New York State Health Maintenance Organizations Conference is a not-for-profit corporation consisting of 27 health maintenance organizations ("HMOs") licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than 2.5 million people in New York. The twelve individual HMOs who also have intervened serve approximately one million people in all parts of the State.

3. As Executive Director of the Conference, I am fully familiar with the operations of HMOs throughout the State. Prior to becoming Executive Director of the Conference, I was the director of marketing for Health Insurance Plan of Greater New York, the largest HMO in the State and one of the oldest in the country. I

also served as the vice-president, marketing at Rutgers Community Health Plan in New Jersey.

A. HMOs AND THEIR ROLE IN NEW YORK'S HEALTH CARE SYSTEM

4. HMO coverage differs from traditional health insurance. By combining hospitalization coverage with the provision of care, HMOs have the incentive to provide high quality health care in the most cost efficient way possible. HMOs accomplish this through a variety of contractual arrangements with doctors, other providers and hospitals. For example, some HMOs (group and staff models) employ their own physicians who act as the primary caregiver to the HMO subscriber. Other HMOs (individual practice associations or "IPAs") use networks of physicians who agree to serve the HMO's subscribers and adhere to the HMO's practice and payment guidelines.

5. HMOs use a number of tools to control the cost of health care, including emphasizing primary and preventive care, managing the delivery of care and seeking to eliminate unnecessary or excessive hospital stays. In recent years, the increase in the cost of HMO premiums has been significantly less than the increase in other types of health insurance.

6. HMOs generally do not themselves provide in-patient hospital care. Rather, HMOs operate as third-party payors of in-patient hospitalization. The cost of hospital reimbursement is a substantial expense of the HMOs and therefore directly affects the cost of health care to HMO members.

7. Unlike commercial insurers which have traditionally relied on experience rating, and unlike Blue Cross organizations, which experience rate groups with more than fifty members, HMOs community rate everyone: large groups, small groups and individuals. HMOs also are required to provide open enrollment to all

groups of five or more employees and last year served approximately 250,000 small group members.

8. HMOs are required by state and federal law and regulations to offer a comprehensive benefits packages. While each HMO's benefits package may have distinctive features, they all share an emphasis on primary and preventive care and cover a wide range of illnesses and conditions. HMOs may not revise their benefits packages at will and may not reduce their package beyond a certain level of benefits.

9. Many HMOs are non-profit, including seven of the individual HMOs who have also intervened in this action. Other HMOs are small and still struggling to increase their membership. Most HMOs do not have large financial reserves that can absorb major and unexpected costs. While HMOs retain reserves, these are to be used for unexpected claims and are not available for unexpected operational costs. In the face of such costs, HMOs are forced to seek rate increases.

10. Finally, unlike other insurers, HMOs serve Medicaid recipients. Under the State's Medicaid managed care program, HMOs enroll Medicaid recipients into their managed care networks and receive a fixed monthly rate for each individual. The HMO bears the full risk for the cost of providing care to the Medicaid member. This is in contrast to the usual Medicaid fee-for-service arrangement in which the Medicaid provider receives a fee for each visit or service. HMOs also insure that Medicaid recipients and their families have a primary physician who monitors their care on a regular basis. This and the availability of a health care network helps reduce costly emergency room visits.

B. HMOs AND EMPLOYEE BENEFITS PLANS

11. In developing their health care benefits packages, many employee health benefit plans seek to provide a choice between

indemnity insurance and HMOs. In addition, State and federal law requires employers (and employee benefits plans) to offer their employees the choice of at least one HMO. Most HMO contracts are with employee benefit plans.

12. After an employee benefits plan contracts with an HMO, the employees and their families must select a primary physician. This is usually a pediatrician for children and an internist for adults. Many women select an obstetrician/gynecologist as their primary physician.

13. The physician has primary responsibility for overseeing the care that is provided. By designating a primary physician, the HMO insures that there is one individual who understands the medical history and needs of each employee and their families. In most cases, members must receive the approval of the primary physician before being referred to a specialist.

14. HMOs also work closely with the patients prior to and during a hospitalization to insure that there is adequate preparatory work and to minimize the length of the hospital stay.

15. As noted above, in some cases the HMO's physicians are salaried employees of the HMO and are available only to serve the members of the HMO. Thus, if an employee benefits group leaves the HMO, the employees and their families cannot continue to use the physicians who they have been using and who may be most familiar with their medical history.

C. HMOs AND NEW YORK'S HOSPITAL REIMBURSEMENT SYSTEM

16. HMOs receive the benefit of the 13% differential. This is because HMOs are required to community rate all of their members, open enroll all groups of five or more and provide extensive community service. The differential also reflects the fact that

HMOs enroll subscribers without imposing preexisting conditions and provide comprehensive benefits packages.

17. HMOs are allowed by statute to negotiate alternative rates with hospitals. HMOs authority to negotiate rates reflects a recognition that HMOs' managed care systems are able to reduce significantly the cost of hospitalization. These rates are set by contract and are outside the case-based payment system. For example, HMOs subscribers often have shorter lengths of stay than people with similar illnesses who are enrolled in Blue Cross or other insurance companies. In fact, many HMOs experienced significant increases in the overall cost of hospitalization when the state moved from a per diem system of reimbursement to a case based system. This was because HMOs were able to minimize the length of stay relative to other insurers and thus had relatively lower costs under a per diem system.

D. THE STATE'S IMPOSITION OF THE 9% SURCHARGE

18. In April, the State enacted a new 9% surcharge on HMO inpatient care. The 9% is not an increase in the rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate monthly cost of the in-patient hospitalization paid by an HMO. It is paid directly to a statewide pool and thereafter deposited into the State's General Fund. In the case of HMOs who have negotiated alternative hospital rates, the 9% is assessed over and above the negotiated rate.

19. Under the statute, HMOs can reduce or eliminate the 9%. For the 1992 rate year, an HMO could eliminate the 9% surcharge if it (1) had Medicaid contracts with every county in which it operated and (2) had enrolled within less than one month of the enactment of the statute a defined target number of Medicaid recipients.

20. For any HMO that did not already have contracts in place and a substantial enrollment, meeting the standards was virtually impossible. The process for obtaining a county contract generally takes at least nine months and HMOs have experienced substantial delays in obtaining contracts from some counties. Some counties have refused to negotiate contracts with HMOs. Since enrollment in an HMO is not mandatory, it can take many more months for an HMO to achieve the enrollment targets.

21. While a few HMOs were able to eliminate or reduce the 9% surcharge for the 1992 year, there is no assurance that they will continue to be able to do so because the enrollment target increases every year. In addition, because there is no across-the-board mandate on Medicaid recipients to enroll in an HMO, some HMOs with sufficient enrollment in one year may lack the requisite enrollment in the next year and thereby become subject to the 9% surcharge.

22. The surcharge has had an immediate and dramatic effect on the rates that HMOs must charge their subscribers. Since the cost of hospitalization accounts for approximately 30% of the overall costs of an HMO, the 9% surcharge translated into an immediate 2.5-3.5% increase in costs for most HMOs.

23. HMOs cannot absorb this increase. They cannot use reserves, which must be retained in the event that an HMO experiences unusually heavy medical claims. Nor can they use corporate profits since most HMOs are non-profit. Thus, they are forced to pass the surcharge on in the form of higher rates.

24. Because the surcharge occurred in the middle of the rate year, most HMOs could not seek an immediate rate increase without going through a special procedure, and they were explicitly discouraged from doing so by the Insurance Department. However, those HMOs that have sought rate increases have received them.

25. In its decisions to award increases, the Insurance Department specifically cited the 9% surcharge as the basis for at least part of the increase.

26. For many HMOs, the outlook for next year is not encouraging. Although many HMOs now have contracts pending with counties or awaiting approval by the State, it is unclear when the contracts will be finalized, and some HMOs must obtain contracts with as many as twenty counties. Moreover, even if an HMO is able to obtain the requisite contracts with a sufficient number of counties, there will be little time to enroll the number of Medicaid recipients necessary to hit the targets. Thus, those HMOs will continue to pay the 9% at least through 1993. Finally, as noted, the target number increases in subsequent years so even those HMOs who now do not pay the surcharge may be forced to begin paying it in future years.

27. By April of 1993, many HMO subscribers will be paying an additional 2.5-3.5% in their rates.

28. Accordingly, the plaintiff's motion for summary judgment should be granted to the extent that it seeks to strike down the 9% surcharge and the defendant's cross-motion for summary judgment should be denied.

KATHRYN ALLEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Paul V. Bruno, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

PAUL V. BRUNO, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for in-patient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore R. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Sales Director, Managed Care and Employee Benefits, Albany, New York. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers and the types of services which The Travelers provides to both insured and self-insured group health plans. In my position I work primarily with group health plans of 500 lives or more.

3. I understand that, in opposition to the motions of the plaintiffs for summary judgment, the interveners, The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue

Cross and Blue Shield repeatedly claim that Blue Cross/Blue Shield plans are losing business at an accelerating and alarming rate because commercial insurance companies have been "cherry-picking" their best customers.

4. From my experience, "cherry-picking" is not an issue with respect to the market I primarily deal with (group health plans of 500 lives or more). In this size market, from the competitive situations I have seen over the years, Blue Cross/Blue Shield offers experience-rated programs and self-insured claims administration. "Cherry-picking" is simply not an issue in the medium-customer and large-customer market.

5. With respect to group health plans of 500 lives or more, my experience is that ERISA plans change from Blue Cross/Blue Shield to The Travelers for reasons that have nothing to do with cherry-picking or community rating, but rather simply that the customer believes The Travelers performance is superior to that of Blue Cross/Blue Shield in areas such as (a) information technology, providing the customer with access to Travelers advanced systems enabling them to respond to employees' benefit inquiries, review claim data, handle eligibility questions, monitor banking arrangements, and other items; (b) fast, accurate claims service, including responsiveness to inquiries from the customer's employees; (c) medical management features which encourage covered individuals to seek quality, yet cost effective, medical care; and (d) plan flexibility, tailored benefit packages to suit the needs of a particular customer, based on the make-up of its employees, including wellness programs, a maternity intervention program, and various claims management programs. Finally most ERISA group health plans of 500 lives or more, that changed from Blue Cross/Blue Shield to The Travelers, complained that they were unhappy with the service provided by Blue Cross/Blue Shield.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgement should be granted.

PAUL V. BRUNO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Terence D. Tuohy, filed October 21 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

TERENCE D. TUOHY, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for in-patient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore R. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Vice President, Managed Care and Employee Benefits, East Hartford, Connecticut. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers, and the types of services which The Travelers provides to insured group health plans. In my position I work primarily with group health plans of 2 to 50 lives at present, although my area of responsibility will be evolving to include group health plans of 2 to 200 lives.

3. I understand that, in opposition to the motions of the plaintiffs for summary judgment, the intervenors, The New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield repeatedly claim that Blue Cross/Blue Shield plans are losing business at an accelerating and alarming rate because commercial insurance companies have been "cherry-picking" the best customers from those plans.

4. Premium rates are very important in a highly competitive market to be sure. However, from my experience, ERISA plans change from Blue Cross/Blue Shield to The Travelers for many other reasons which have nothing to do with community rating by Blue Cross/Blue Shield or risk underwriting rules utilized by The Travelers. Rather, customers come to The Travelers for a wide variety of reasons, including:

a. the fact that The Travelers name is an old and respected name in the health insurance field;

b. the broad array of products, available through The Travelers, including unmanaged indemnity, managed indemnity, preferred provider organizations, point of service plans in some areas, health maintenance organization plans in some areas, and variations on these options;

c. high levels of efficient and responsive customer service, including the fact that The Travelers is highly automated and, for example, customers can receive employee booklets within 48 hours of entry of the relevant data into the system;

d. the offering of ancillary benefits, including life insurance, dental insurance, and insurance for lost wages while out on disability;

e. the fact that The Travelers has four claims offices dedicated exclusively to handling claims for the 2 to 50 life market;

f. the fact that The Travelers is a strong supporter of the agency system, as we believe smaller, less sophisticated employers benefit significantly from the assistance of an agent in the complex world of health coverages today;

g. enhanced claim review and claims payment processes which result in high quality care, yet appropriate, cost effective care.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgment should be granted.

TERENCE D. TUOHY

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Richard W. Landen, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

RICHARD W. LANDEN, being duly sworn, deposes and says:

1. I am an independent health care consultant. Between September 1987 and September 1992, I was a full-time employee of the Health Insurance Association of America ("HIAA") in Washington, D.C. From 1987 through 1990, I was the Associate Director of the HIAA's Insurance, Managed Care and Professional Relations Department. One of my primary duties was representing the HIAA in matters relating to hospital reimbursement issues in New York State. Prior to joining the HIAA, I was Assistant Administrator at the New York Infirmary Beekman Downtown Hospital (NYIBDH), a not-for-profit voluntary acute care hospital in New York City. I was at NYIBDH for eight years, beginning in 1978 as an administrative resident. I hold the degrees of Master of Public Health and Master of Business Administration, conferred by Columbia University in New York City, where my academic concentration was health care administration. I am familiar with the operation of the hospital reimbursement system in New York State.

2. I submit this affidavit in support of the plaintiffs' motions for summary judgment in *The Health Insurance Association of America, et al., v. Chassin, et al.* and *The Travelers Co. v. Cuomo, et al.*, and in opposition to the cross-motions filed in both actions.

3. I have reviewed the affidavits submitted by the State defendants and the Intervenors in these actions. The purposes of this affidavit are: (a) to respond to the State defendants' and Intervenors' characterizations of the 13% differential and its predecessors; and (b) to demonstrate that the commercial insurance industry, through the HIAA (a trade association of hundreds of private insurance companies) has objected to the differentials throughout their history.

A. SUMMARY.

4. At the outset, I note that the history of the differential is not as the State defendants and Intervenors would have it. They seek to portray the differential as a device designed by the Legislature to level the playing field between Blue Cross and the commercial insurance industry. The facts, however, are somewhat different. As described below, the differential sprung from an unregulated market. Hospitals were limited in the amounts by which they could raise Blue Cross rates, but were not similarly limited with respect to private sector charge payors. This situation led to a gross disparity in the rates at which Blue Cross plans and other payors (such as commercial insurers and self-insured plans) reimbursed hospitals for inpatient care. When New York enacted its first cost-control legislation, the differential was arbitrarily frozen into the law. Further, committees that have been charged with the responsibility of studying the differential have conceded that it lacks a quantifiable basis and should be phased out.

5. Further, throughout the NYPHRM era, the commercial insurance industry has objected to the differential, specifically noting that it lacks any quantifiable basis and has outlived the historical conditions that created it.

B. THE "MARKETPLACE" IN WHICH THE DIFFERENTIAL OPERATES.

6. In seeking health care benefits, employee benefit plans and others seeking health coverage have two principal objectives. First, they seek to protect themselves against the risk of catastrophic health care costs that would jeopardize their financial position. Second, they seek to minimize the costs of that coverage—by, among other things, paying premiums no larger than those justified by their risk, controlling the amount of claims paid, and capturing savings they are able to achieve.

7. These objectives have different implications for different types of plans. For instance, relatively large group plans often conclude that their best option is to bear most or all of their own risk. Because of their size, those plans may be in a position to cover the risk of catastrophic losses that materialize for only a relatively few participants, and they often have the incentive and the ability to control their own costs (perhaps with the help of a commercial insurer) and to capture resulting savings.

8. By contrast, smaller groups and individuals often seek coverage primarily as protection against the risk of losses they themselves would be hard-pressed to bear; they may choose to share their risk by purchasing insurance and contributing premiums to a pool used to pay claims. Intermediate options, involving some combination of risk sharing and risk retention, may be selected, depending on the characteristics of a given group and its willingness to assume risk.

9. Various forms of health coverage are available to satisfy the varying needs of employee benefit plans and others. Some are insurance and some are not. Specifically, plans may choose to self-insure (with or without stop-loss coverage that limits their retained risk), to participate in HMO's, or to purchase insurance.

Insurance is available on terms that involve more or less sharing of risk.

10. Commercial insurers and Blue Cross compete in providing coverage through a number of these mechanisms. In addition to providing coverage on a community-rated basis, Blue Cross administers self-insured employee benefit plans, offers insurance on an experience-rated basis (tying premiums to claims experience), and operates HMO's. Indeed, more than two-thirds of the Intervenor Empire Blue Cross and Blue Shield's premiums are derived from insurance that is not community-rated.

C. HISTORY OF THE 13% DIFFERENTIAL.

11. The affidavit of Albert F. Antonini begins its discussion of the "Historical Use of [the] Differential to Regulate Insurance Markets" by referring to the Trussell Report (*see* Antonini Aff. ¶¶ 15-20 & Exhibit A.) The New York Legislature commissioned the Report in the late 1950's as part of a sweeping study of the New York State Blue Cross Plans. However, this Report says nothing about the differential. Indeed, it suggested that Blue Cross income be supplemented by public subsidy (*see id.* p. 44)—not by charges levied on Blue Cross's competitors in the health-care coverage market.

12. Prior to New York's adoption of the prospective hospital reimbursement methodology (known as "NYPHRM") in the early 1980's, the State did not regulate the ways hospitals charged or the rates at which commercial insurers and self-insured plans reimbursed hospitals for inpatient care. These entities reimbursed hospitals according to the hospitals' charges. In 1969, a prospective payment system was set up; this system limited hospital reimbursement rates for Medicaid and Blue Cross. During the 1970's, an inflation "trend factor" was established which set permissible yearly rate increases for Blue Cross. No such limitation was set for commercial insurers or self-insured plans. This

rate of increase destroyed any incentive for Blue Cross to develop hospital cost-control programs with the result that hospitals looked to charge-payors to capture cost elements not realized under the Blue Cross prospective payment system. Further, where yearly Blue Cross rate increases were insufficient to meet the financial needs of individual hospitals, they were free, until 1978, to escalate their charges. This led to a significant cost shift to charge payors. Thus, the Blue Cross discount grew larger.

13. In 1978, a charge control system was put in place for hospitals, covering all patients. This system limited the yearly rate of increase in charges to an overall hospital inflation rate. This system, however, froze the existing differential, and maintained the burden placed on charge-paying patients.

14. NYPHRM-I codified the differential for the first time, and set the maximum differential at 15%. Significantly, the method chosen to do this was for the State Health Department to require hospitals to set aggregate charge levels at no more than 15% above their Blue Cross reimbursement rate. Thus, the concept was targeted at all payors, including uninsured individuals, not just insurance companies.

15. The Hospital Association of New York State ("HANYS") is incorrect in stating that the HIAA "strong[ly] support[ed]" the NYPHRM-I legislation. Even a cursory reading of the basis for that assertion—a July 12, 1982 letter from HIAA to Governor Carey (*see Sisto* Affidavit ¶ 14 & Exhibit G)—demonstrates HIAA's concern with the "fragmented, arbitrary and unfair health care reimbursement practices in New York State." Significantly, this letter states in part that the NYPHRM-I legislation "continues to permit payment inequities among third-party payors that are not yet objectively justified." Thus, the HIAA's support of NYPHRM-I certainly was not without reservation. Its support of the legislation was driven by its recognition that NYPHRM-I was "a major step towards" a system uniformly fair to all "third party

payors." From the outset, however, the HIAA made its objection to the differential clear.

16. While the first NYPHRM legislation was in effect, the New York State Hospital Review and Planning Council ("SHRPC") undertook a study of the differential, pursuant to a legislative mandate in the NYPHRM law. The "Charge Differential Analysis Committee" (otherwise known as the "Komaroff Committee," after its chairperson, Mr. Stanley Komaroff) of the SHRPC conducted the review. The Komaroff Committee solicited interested parties to submit papers on the value of the Blue Cross discount, including recommendations regarding maintenance or modification of the Blue Cross discount on and after January 1, 1986.

17. The HIAA submitted a paper, dated December 28, 1984, which directly challenged the justification of the differential. In that paper, a copy of which is annexed hereto as Exhibit A, the HIAA noted the following:

- No quantification of the value of the Blue Cross discount was made before it was incorporated into New York's hospital revenue control law; instead, it was related to the historical discount enjoyed by Blue Cross. The historical discount arose from New York's imposition of a prospective payment system only on Medicaid and Blue Cross. This system restricted rates of increase of Blue Cross payments to hospitals. It was in recognition of a lack of basis for the differential that the Legislature mandated that the SHRPC determine its true value.

- MNYPHRM-I was enacted in 1982 to impose a more rational system of cost control on hospitals. The statute broke new ground in incorporating charge and other payors with Medicare, Medicaid and Blue

Cross into a uniform hospital reimbursement system.

- Experience in Maryland and New Jersey, where Blue Cross enjoyed large discounts and large market shares prior to regulatory action significantly lowering the discount in those states, demonstrated that Blue Cross market share remained virtually unchanged.

- The NYPHRM-I discount (a maximum of 15%), although less than some historical, pre-NYPHRM differentials that operated in Blue Cross's favor, nevertheless was not cost-justified. It was a purely arbitrary figure temporarily imposed pending completion of a study of the value of Blue Cross practices.

- Blue Cross was still being rewarded for practices that met needs existing in the 1930's and 1940's. Those needs, however, had since been addressed by the introduction of Medicare and Medicaid. By virtue of these programs, the elderly and the indigent received coverage for health care services through state and federal tax dollars.

- Further, access to private health insurance for employed segments of the population was met equally well by commercial insurance and Blue Cross policies. The then-current marketplace dominance of the Blue Cross plans was due to the fact that they enjoyed a differential allowing them to offer a product similar to that being offered by commercial carriers at a much lower price. This advantage was magnified by tax exemptions which the commercials were not allowed.

18. Significantly, the HIAA stated that there was no data to justify the existing differential:

The NYPHRM legislation calls for Blue Cross to have no more than a 15% discount until December 31, 1985, with a discount to be set by the SHRPC, not to exceed 12%, to be effective after that date. There was no study or data submitted by any parties during the NYPHRM legislative discussions surrounding this issue that attempted to quantify what, if any, value there is to Blue Cross practices that merit a discount of any magnitude. The decision regarding an interim discount was not based on a quantitative evaluation of Blue Cross activities aimed at reducing hospital costs. Because of the complexity of the issue, it was agreed by all interested parties that an objective evaluation should be deferred until after NYPHRM was implemented. The commercial insurance industry agreed not to oppose the interim Blue Cross discount with the understanding that the SHRPC would undertake a determination of its true value.

19. In May 1985, the Komaroff Committee submitted its first report to the SHRPC regarding the differential (the "first Komaroff Report"; *see* Antonini Aff. Exhibit E). The first Komaroff Report explicitly noted that "the basis of the differential is not currently susceptible of precise quantification, and historically has not been so." (*Id.* at pp. 3-4.) It also noted that the "social policy factors" purportedly justifying the differential "and the cost or price thereof are in large part subjective, conjectural and uncertain." (*Id.* at p. 5.)

20. The first Komaroff Committee, believing in "gradualism," recommended that in the years 1986 and 1987, the differential be reduced to 12%, contingent upon expansion of the open enrollment periods of all the Blue Cross plans. The Committee recommended that in 1988 the differential be further reduced to 10% unless prior to that time the SHRPC decided otherwise. It also called upon the SHRPC to begin further review of the appropriateness of the differential in 1987. (*Id.* at pp. 8-9, 11.)

21. The dissent to the first Komaroff Report, registered by one of the Committee members, Bernard Handel, went even further. A copy of Mr. Handel's dissenting report is annexed hereto as Exhibit B.

22. Among other things, Mr. Handel noted that "the overwhelming majority" of comments and reports received by the Committee (which were not summarized in its report) favored a reduction in the differential and negotiation between individual employee benefit plans and hospitals regarding the details of reimbursement. (Exhibit B, hereto, at p. 1.) Some of Mr. Handel's additional points included the following:

- The differential is not quantitatively defensible. (The Committee actually agreed with this point.)

- Gradual reduction in the differential should be expedited and started in 1986.

- An excess differential provided to any one carrier lessens competition among insurance companies and self-insured plans and leads to higher premiums.

- The evidence submitted to the Committee indicated that the then-existing differential "far exceeded its desired social objective of subsidizing losses incurred by Blue Cross in meeting identifiable social objectives."

- New York State policy should not single one carrier out for protection; it should be equitably applied to all third-party payors.

23. NYPHRM-II, enacted in 1985, set the differential at 12%. Once again, as the HANYS notes, HIAA wrote to the Governor's Counsel and recommended that the legislation be approved. (*See*

Sisto Aff. ¶ 18 & Exhibit H.) It noted that NYPHRM was "preferable to the method of hospital reimbursement which previously prevailed," but at the same time urged that New York "promptly begin to develop the details of a comprehensive, long term solution to hospital financing in New York." In addition, HIAA made the following recommendations, among others:

- New York's hospital reimbursement system should be revised to permit all payors to negotiate reimbursement agreements with hospitals, provided they do not operate to shift costs among payors.

- The differential should be given further study, and continuing attention should be paid to its reduction.

24. NYPHRM-III was passed in January 1988 and governed reimbursement for inpatient hospital care until December 31, 1990. This legislation contained a 13% differential. Once again, HIAA supported the legislation, rejection of which "would result in a legislative framework devoid of effective charge control and open to the unabated cost shifting which occurred prior to NYPHRM." (Sisto Aff. Exhibit J.) At the same time, and as it had done in the past, the HIAA outlined its "concerns" with the bill. (*Id.*) Among other things, the HIAA opposed the "undefined, unquantified granting of a differential to Blue Cross, HMO's and Medicaid which amounts to a 13% mark-up of rates" to other-payors; instead, the HIAA recommended that payment rates be set equitably for all payors "based on the resource consumption of the payor or group of payors participating in the system." (*Id.*)

25. It is worthy of note that NYPHRM-III provided for a reduction of 2% in the differential applicable to a commercial insurer that practiced open enrollment practices and charged rates comparable to Blue Cross during a period set in the statute. Similarly, the law provided for a 2% reduction in the differential

applicable in any region where the Blue Cross plan with the largest number of subscribers was not practicing open enrollment practices during the periods set forth in the statute. (*See* Antonini Aff. Exhibit G.) Thus, the New York Legislature effectively conceded that the economic worth of the differential's social value was 2% rather than 13%.

26. Pursuant to legislative direction in NYPHRM-III, the Komaroff Committee undertook another review of the differential.

27. Once again, the HIAA submitted its views in a paper, dated November 4, 1988, a copy of which is annexed hereto as Exhibit C. In this paper, the HIAA made its opposition to the differential clear, noting that whatever the past merits of awarding the differential might have been, there was no longer any basis for doing so. The HIAA pointed out the following, among other things:

- Despite Blue Cross's philosophy of pursuing social policy objectives, New York had the highest rate of uninsured in the Northeast, to the tune of some 2.4 million.

- The GAO concluded that there was little difference between Blue Cross plans and commercial insurance; Blue Cross's federal tax exemption thus was removed.

- The differential imposes an adverse impact on commercial insurers and other charge payors.

- Blue Cross was then selling an increasing percentage of experience-rated contracts, which at that point amounted to nearly 80% of all hospital certificates issued by Empire Blue Cross.

- Blue Cross was expanding its ASO business, in which it acts as third-party administrator for self-insured groups.

28. In February 1989, the Komaroff Committee issued its second report, roughly four years after issuing its first. (A copy of the second Komaroff Report is annexed as Exhibit K to the Antonini Affidavit.) Despite the passage of time, however, the second report stated that "[n]o calculation can be formulated to precisely quantify the appropriate differential level." (Antonini Aff. Exhibit K at p. 4.)

29. With regard to the social policy factor, however, the second report recognized, among other things, that

- There had been a reduction in the number of subscribers recruited through open enrollment policies.

- Blue Cross had shifted a significant number of subscribers from community-rated to experience-rated plans.

- There was "ample (and distressing)" evidence of a rise in the number of the uninsured and under-insured in New York, notwithstanding the existence of the differential.

- Blue Cross had taken advantage of the differential in situations where it functioned merely as the third-party administrator of plans underwritten by other insurers (*i.e.*, Blue Cross functioned as the administrator pursuant to an ASO Agreement).

Despite the absence of "precise information regarding the value of the differential," the second report recommended that the differential of NYPHRM-III be continued in 1991 (and for a

"reasonable period" thereafter). At the same time, however, the second report stated that there was no "unanimity" regarding this position, and that the differential "should be reduced on a gradual basis, and ultimately phased out, except to the extent that a direct and quantifiable link can be forged between the differential and appropriate social goals." (Antonini Aff. Exhibit K at p. 7.)

30. In March 1989, the Subcommittee on Health Insurance of the New York State Council on Health Care Financing also issued a report regarding the differential. (A copy of this report is annexed as Exhibit L to the Antonini Affidavit.) The Subcommittee Report noted that "it is difficult to precisely set and value the appropriate differential level." (Antonini Aff. Exhibit L at p. 5.) As had the Komaroff Committee, the Subcommittee Report recommended that the differential be continued in 1991 and for a reasonable period thereafter, but it acknowledged that it did so "in the absence of precise knowledge of the nature of the post-NYPHRM III hospital inpatient reimbursement system, and other public policy objectives which might be undertaken to achieve the objectives which the differential is intended to achieve." (*Id.* at p. 6.)

31. Thus, the groups that have been charged with the responsibility of studying the differential have conceded that it lacks a quantifiable basis, and should be phased out.

32. The differential was carried over into the next phase of NYPHRM legislation. In 1990, the New York Legislature enacted NYPHRM-IV. NYPHRM-IV contains a 13% differential and regulates the rates at which hospitals are reimbursed for inpatient care for the period January 1, 1991 through December 31, 1993. I am informed by counsel that the 13% differential of NYPHRM-IV is challenged in this lawsuit on ERISA preemption grounds.

33. In sum, the history recounted above shows that the New York Legislature and the committees assigned the task of studying the differential were responsive to the HIAA's position that the differential lacked an objective justification. Thus, there was cause for optimism that, in light of the absence of such a justification, the differential would be reduced or eliminated.

34. Finally, I note that to the extent the differential has been subjectively justified as a reward for Blue Cross's community-rating and open-enrollment practices, in July 1992, Governor Cuomo signed legislation (Chapter 501 of the Laws of 1992) requiring commercial insurers to adopt these practices, effective April 1, 1993, in their underwriting of individual and small group plans. Thus, Blue Cross can no longer claim an entitlement to the differential based on its assertedly "unique" implementation of these practices.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment should be granted.

RICHARD W. LANDEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Chris Petersen, filed October 21, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

CHRIS PETERSEN, being duly sworn, deposes and says:

1. I am employed as Senior Counsel to the Health Insurance Association of America ("HIAA"). In that capacity, I have concentrated in state legal affairs and for the past three years, I have had direct responsibility for New York legislative actions impacting the health insurance industry. I understand that plaintiffs in these actions are challenging, on ERISA preemption grounds, the 11% surcharge recently enacted in Section 348 of New York's Omnibus Revenue Act of 1992 (the "Omnibus Act"). I further understand that plaintiffs in the action entitled *The Health Insurance Association of America, et al. v. Chassin, et al.*, No. 92 Civ. 5419 (LJF), are raising a similar challenge with regard to the 9% surcharge recently enacted in Section 349 of the Omnibus Act. I frequently traveled to New York to engage in lobbying activities with regard to these surcharges, and was extensively involved in formulating industry positions with respect to them. I an familiar with the surcharges' legislative history.

2. I submit this affidavit in support of the plaintiffs' motions for summary judgment in *The Health Insurance Association of America, et al. v. Chassin, et al.* and *The Travelers Insurance Co.*

v. Cuomo, et al. and in opposition to the cross-motions filed in both actions.

3. I understand that the State defendants, Intervenor Blue Cross and Blue Shield and Intervenor New York State Conference of Blue Cross and Blue Shield Plans characterize the new 9% and 11% factors as nothing more than extensions of the 13% differential, thus portraying them as the same thing — a State imposed discount favoring Blue Cross as a reward for its pursuit of socially desirable goals. This is a mischaracterization. The 9% and 11% factors are designed to assist in balancing New York's budget.

4. Indeed, Governor Cuomo's Memorandum in support of a proposed predecessor to Section 348 of the Omnibus Act (which would have imposed an additional *12%* on the amounts commercial insurers paid to hospitals for the cost of inpatient care instead of the 11% ultimately contained in the Omnibus Act) succinctly stated as follows:

> Enactment of this bill is necessary to implement the Governor's plan to eliminate the deficit for the 1991-92 Fiscal Year.

A copy of the this Memorandum is annexed hereto as Exhibit A.

5. The Bill Memorandum accompanying Assembly Bill A.10565 (the Omnibus Act) similarly provides:

> This bill contains the revenue and financing measures necessary to complete the 1992-1993 State budget.

A copy of this Memorandum is annexed hereto as Exhibit B.

6. In remarks recorded prior to the New York Senate's vote on S.7589 (the Bill that became the Omnibus Act), various Senators

noted that these new factors unfairly discriminate against commercial insurers and will lead to increases in insurance premiums, all in the name of balancing New York's budget.

7. For example, Senator Solomon stated, in part, as follows:

> The message is clear that we'll balance this budget by raising the cost of health insurance and raising hospital costs instead of taking actions that could reduce fees for doctors and hospitals and attempts to limit those costs.
>
> * * *
>
> We have now placed an additional 11 percent surcharge against private health insurance carriers in this State. Do we take the money and use it for the health care system? Nope. We take it and we put it in our general fund.
>
> * * *
>
> * * * [W]e've even tacked 9 percent onto the HMOs in this state because we want to make sure that a lot of the people share in this increase in health insurance costs and health care costs.

(*See* Exhibit C, hereto.)

8. Thus, it is clear that a purpose of the 9% and the 11% surcharges was to balance New York's budget. Although Blue Cross endorsed the legislation as a means of enhancing its position in the marketplace, this was not the sole or even the main purpose of the legislation.

9. Finally, I understand that the Intervenors argue that plaintiffs' challenges to the 13% differential are barred by the doctrine of laches since, according to Intervenors, the HIAA supported the

differential throughout its history and allegedly unreasonably delayed its challenge until it brought this lawsuit. As recounted in the affidavit of Richard W. Landen, submitted in further support of plaintiffs' motions, the HIAA actually has opposed the differential throughout the NYPHRM era. The differential generally has followed a downward trend since the pre-NYPHRM years. As a result, the commercial insurance industry was optimistic, based on reviews of the differential conducted by direction of New York's Legislature, and the HIAA's participation therein, that it could use New York's legislative and regulatory processes to eliminate the differential. However, enactment of the new 11% surcharge sent the commercial insurance industry a clear message that it could no longer rely on these processes to achieve its goal.

WHEREFORE, it is respectfully submitted that plaintiffs' motions for summary judgment should be granted.

CHRIS PETERSEN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed October 29, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn, deposes and says:

1. I am Chief Financial Officer of Empire Blue Cross and Blue Shield (hereinafter "Empire"), a member of the New York State Conference of Blue Cross and Blue Shield Plans (hereinafter "the Plans"), both Intervenors in this action. I execute this Affidavit in Reply to the Affidavits of Paul V. Bruno and Terence D. Tuohy submitted in further support of Plaintiff Traveler's motion for summary judgment and the Affidavits of Richard W. Landen and Chris Petersen submitted in further support of Plaintiffs HIAA'S, *et al.* motion for summary judgment.

2. In the aforementioned affidavits, the Plaintiffs attempt to: (1) minimize the significant differences between the Blue Cross and Blue Shield Plans and commercial insurers *(see* Bruno and Landen Affidavits); (2) establish that the lower premiums offered by commercial insurers have not caused subscribers to terminate coverage offered by the Plans *(see* Bruno and Tuohy Affidavits); and (3) revise history to distort the purpose of the differential including asserting that the recent additional 9% and 11% differentials were intended solely to redress the State's fiscal problems (*see* Landen and Petersen Affidavits). Plaintiffs' attempts fail because they are not supported by established facts, are inconsistent with legislative history and are, in any event, irrelevant to the legal issue presented.

A. COVERAGE PROVIDED BY PLANS DIFFERS FROM COMMERCIAL COVERAGE.

3. The Bruno Affidavit states that a majority of Empire's business involves large experience rated groups and that Empire gains a large proportion of its premium income from providing this coverage. The implication is that the Plans are no different than commercial insurers and should not have a differential. Similarly the Landen Affidavit attempts to minimalize the importance of the differential to the Plans' ability to operate in their historical fashion by portraying the Plans as operating more and more like commercial insurers.

4. As outlined in my prior Affidavit, ¶¶ 18-23, the purposes and operations of the Plans have been and continue to be significantly different from those of the commercial insurers. These differences are not merely limited to the Plans' community rating and open enrollment, but include operating as not-for-profit corporations, providing advance payments to hospitals and continually being at the forefront of public policy initiatives.

5. Empire's offer of experience rated coverage, similar to the coverage provided by commercial insurers, should not in any way blur the distinction that it operates in a significantly different manner than commercial insurers. First of all, Empire's community rated contracts constitute approximately 30% of its business, which represents health insurance coverage to over 1.5 million subscribers, many of whom could not obtain insurance coverage at all from any of the Plaintiffs. As stated in paragraph 28 of my previous Affidavit, other Plans in the State have a much greater percentage of community rated contracts, and even community rate large groups such as Kodak and Xerox.

6. One way that Empire, as well as the other Plans, can continue to offer individual coverage and Medicare supplementary coverage at premium levels that are affordable, is to subsidize the losses on such coverage to a certain extent. In fact, Insurance Department regulations, 11 NYCRR § 52.40(g)(1), require that the rates on experience rated contracts contain a specific community service factor to be paid into the Plans' reserves to subsidize losses incurred by the Plans on community rated contracts.

7. Any substantial erosion in the Plans' ability to compete in the large group health insurance marketplace would have a direct adverse impact on the Plans' ability to subsidize its community rated contracts and thereby the ability to offer coverage at such affordable prices.

8. Because all of the Blue Cross and Blue Shield lines of business benefit from the differential, the differential permits the Plans to remain competitive so that they can maintain an experience rated base to support their community rated coverage program.

B. COMMERCIAL INSURERS "CHERRY PICK" GOOD RISKS FROM THE COMMUNITY RATED POOLS.

9. In my prior Affidavit, I outlined in detail the deterioration of Empire's small group community rated pools. This deterioration lead to the Legislature's increase in the differential for commercial insurers. Those facts set forth related to small groups only. Therefore, statements in the Bruno Affidavit that cherry picking does not occur in the large group market are irrelevant.

10. The position taken in the Tuohy Affidavit implying that cherry picking does not occur in the small group market is wholly unsupportable. The commercial insurers, including Travelers, have cherry picked from Empire's community rated pools. The

commercial insurers have lured good risks from the pools by offering lower premiums to those groups.

11. Recently, Empire contracted with the Gallup Organization, Inc. (hereinafter "Gallup") to conduct a survey to determine the reasons for its loss of small group customers. Gallup surveyed more than 1,000 group administrators of community rated groups that canceled Empire's coverage during the first eight months of 1991 to determine whether or not those small groups had subsequently purchased coverage and, if so, to obtain information such as the reasons for cancellation and the name of the current health carrier.

12. Of those groups, over 61% terminated their contracts with Empire and obtained subsequent coverage through commercial insurers.

13. The survey further showed that 78% of the groups which purchased coverage from commercial insurers did so because of price: 80% of this amount realized cost savings of over 10% and 43% received savings of 25% or more.

14. The Gallup survey also identified the commercial insurers from which the small groups obtained their subsequent health insurance. Approximately 3% of Empire's lost contracts obtained subsequent health insurance coverage with the Plaintiff Travelers, 4% obtained coverage with Plaintiff Aetna and 4% obtained coverage with Plaintiff Mutual of Omaha.

15. Empire has also determined that groups which were lured away from the community pools to commercial coverage were groups which are healthier than those groups remaining. For example, during 1990, the average loss ratio of groups that canceled in favor of commercial coverage is almost half the loss ratio of Empire's remaining community groups.

16. In fact, the Travelers itself blatantly discriminates in regard to the groups it will insure. Attached hereto as Exhibit "A" is a list of industries to which Travelers will not offer health insurance. So, for example, when Travelers markets groups belonging to Empire's community rated pools, it offers or provides coverage to groups only from particular industries leaving the groups with higher risks in the listed restricted industries in Empire's community rated pool.

17. Due to the cherry picking, there is a higher percentage of poor risks than ever before in Empire's community rated pools. Even a few years ago, there were 10 good risks in the pool for every one poor risk. Now, there are only three good risks for every one poor risk and it appears that the cherry picking is accelerating as the effective date approaches for the mandatory small group community rating and open enrollment requirements.

18. As of April 1, 1993, the effective date of small group community rating legislation, the need and purpose of the differential will not disappear. In any event, the 13% differential will still be in effect, while the 11% differential expires March 31, 1993. As for a differential generally, the Plans will still subsidize individual and Medicare supplemental coverage while Plaintiffs do not. Secondly, it will take several years for the new community rating legislation to have an impact on the Plans' current populations of community rated subscribers. Due to the years of cherry picking by Plaintiffs and other commercial insurers, they have a much smaller proportion of high risk persons in their pools. Conversely, the Plans' community rated pools have a much larger proportion of high risk individuals.

19. In fact, the payment by the commercial insurers of the additional 11% differential would have assisted the Plans in improving their community rated pools before the effective date of the new legislation by putting the Plans in a position to attract some better risks. Unfortunately, since the commercial insurers

have paid no attention to the legislation requiring them to pay the additional 11% in hospital reimbursement, it has had no impact on the Plans' ability to compete for the good risks in the small group market. If an injunction is granted, as requested by Plaintiff Aetna and Mutual of Omaha to relieve the commercial insurers of the requirement to pay the additional differentials, the downward slide of the community rated pools will continue, making it more and more difficult for the Plans to attract new good risks.

C. LEGISLATIVE HISTORY AND PURPOSE OF DIFFERENTIALS.

20. As noted in my prior Affidavit, ¶ 56, HIAA's senior counsel, Chris Petersen, now an affiant in this action on behalf of HIAA, has acknowledged that the purpose of the differential is to compensate the Plans for engaging in community rating and open enrollment. Plaintiffs' Reply Affidavits have made no effort to contradict that statement.

21. Instead, in the Landen Affidavit, HIAA attempts to alter the history and purpose of the differential by raising questions as to whether the value of the differential is quantifiable. However, the appropriate level of the differential is wholly irrelevant to the issue of ERISA preemption.

22. Plaintiffs' dissatisfaction with the Legislature's enactment of the differentials, as set forth in the Plaintiffs' Affidavits, are the same policy arguments which Plaintiffs submitted to the Legislature and the Kamoroff Committee over the years. Having lost those arguments in the Legislature, the Plaintiffs now seek to reargue the merits of their policy views in court.

23. Whether the differential should be 2%, 10% or 50% does not alter the legislative history or purpose of the differential. In enacting the 13% differential, as well as the subsequent differen-

tials, the New York State Legislature has established a value for the community services engaged in by the Plans. Simply stated, the differential has been used by the state in its efforts to level the playing field in the health insurance market place. *See* Antonini Affidavit for in-depth discussion of legislative history. In fact, even Bernard Handel, noted by Plaintiff to be a "dissenter" from the Kamaroff Committee findings, concludes his report (Exhibit "B", p. 4 to the Landen Affidavit) noting that the differential should be reduced, rather than eliminated.

D. DUAL PURPOSE OF DIFFERENTIALS.

24. All of the differentials have been enacted in the State's proper exercise of its police power to regulate cost control and the insurance marketplace. In fact, all of the differentials have a dual purpose. The 13% differential also provides additional revenues to hospitals to provide and improve patient care. *See* Exhibit "E" to Antonini Affidavit, the first Kamaroff Committee Report.

25. The other differentials, the 9% and the 11%, provide additional revenues to the State of New York, rather than to the hospitals.

26. However, the additional differentials were not enacted for the single purpose of providing revenues to the State of New York, as the Affidavit of Chris Petersen asserts. Although the additional differentials were enacted as part of the budget process, the legislative discussions and consideration which lead to the enactment establishes the other purposes sought to be accomplished. As discussed in Paragraphs 49-63 of the Antonini Affidavit, serious efforts to increase the differential from 13% were under consideration since the 1991 legislative session. To attempt to say the additional differentials were enacted solely for revenue raising ignores the testimony at legislative hearings aimed at encouraging insurers to engage in less restrictive underwriting and community rating, *see* Exhibits "O" and "P" to the Antonini

Affidavit. As the Superintendent of Insurance noted in 1992 Senate hearings, "the current [13%] differential and favorable tax treatment are insufficient to offset the costs associated with accepting poorer risks." Exhibit "P" to Antonini Affidavit, p. 14. Furthermore, the Governor reiterated the dual purposes for the increased differentials: to "both raise revenues for the State and provide competitive support for Blue Cross, which serves higher risk residents." Exhibit "S" to Antonini Affidavit.

JERRY WEISSMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Robert A. Sujecki, filed November 6, 1992

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

ROBERT A. SUJECKI, being duly sworn, deposes and says:

1. I submit this affidavit in support of the motion of plaintiff The Travelers Insurance Company ("The Travelers") for summary judgment declaring that certain provisions of the New York Public Health Law, establishing a 13% surcharge on the amount paid by a self-insured fund for inpatient hospital care and an aggregate 24% surcharge on the amount paid by a commercial insurer for such care, are preempted by the Employee Retirement Income Security Act ("ERISA"), and that Actuarial Letter No. 5 issued by defendant Salvatore F. Curiale is also preempted by ERISA.

2. I am employed by The Travelers as Assistant Actuary, Managed Care and Employee Benefits. As such, I am fully familiar with the group accident and health insurance policies issued by The Travelers, and the types of services which The Travelers provides to both insured and self-insured group health plans. I understand that with regard to the pending motions for summary judgment, the defendants and intervenors have taken the position that plaintiffs have failed to show that the differentials at issue impact the premiums charged to ERISA plans or the benefits provided by such plans. I do not understand how the defendants and intervenors can take this position in light of the affidavit,

sworn to on August 17, 1992, which James M. Gutterman of The Travelers previously submitted in connection with the pending motions for summary judgment. In paragraph 9 of that affidavit, Mr. Gutterman explained that as the costs of the medical treatment covered by The Travelers under a group policy increase, The Travelers passes the costs through to the plan by increasing the premium. In paragraph 14 of the affidavit, Mr. Gutterman explained that with regard to the B.H. Policy, The Travelers sets the premium for the B.H. Policy once a year to reflect the cost of providing coverage, including the cost of inpatient hospital care. He then went on to explain that the 24% surcharge would undoubtedly increase the amount of the premium charged for group accident and health insurance for the beneficiaries of the B.H. Aircraft plan. In light of these clear and concise factual statements, I do not understand how the defendants and the intervenors can take the position that The Travelers might absorb the full impact of the surcharges by reducing its profit margin.

3. Since the 11% surcharge was enacted in April of this year, The Travelers has been increasing the premiums on group accident and health insurance policies when a plan's policy comes up for renewal to reflect the impact of this surcharge. For instance, Denooyer Chevrolet, an insured plan in New York State, recently renewed its group health and accident insurance policy with The Travelers. At renewal, we increased the annual premium for medical benefits on the policy by 7.3%, reflecting projected claim experience and expense charge anticipated for the coming plan year. Of this 7.3% increase, approximately 2.5% was to reflect the 11% surcharge. Other plans have experienced increases in premiums of 2% to 5% as a result of the 11% surcharge. Obviously, if Denooyer Chevrolet did not have to pay this additional premium, it could use the money at issue to provide other benefits to members of the plan or to reduce the overall costs of the plan.

4. The 13% surcharge has existed for a number of years, and I, therefore, cannot point to a specific increase in premiums this year as a result of the surcharge. However, based on a breakdown of the various charges incurred by The Travelers in providing coverage to insured plans, the 13% surcharge represents approximately 2% to 5% of the premiums paid by an ERISA plan for group accident and health insurance. In the case of Denooyer Chevrolet, the 13% surcharge constitutes approximately 3.2% of the health claims.

5. With regard to self-insured plans such as the Sheridan Catheter Plan, the plan pays the entire expense of the 13% surcharge. In the case of the Sheridan Catheter Plan, the 13% surcharge will cost the plan approximately 2.4% of health benefit costs for 1992. Obviously, the plan would use these funds to provide other benefits or to reduce the overall costs of the plan if the 13% surcharge did not exist.

6. In sum, the surcharges at issue here have a material financial impact on both fully insured and self-insured plans. Overall, The Travelers estimates that for the period April 1, 1992 through April 1, 1993, the 13% surcharge will cost the 91 self-insured ERISA plans covering New York residents, with regard to which The Travelers provides claims administration services, a total of $14,000,000. The Travelers further estimates that the 11% and 13% surcharges will cost the 4,338 ERISA plans which receive group health insurance from The Travelers covering New York residents, a total of $24,000,000 for the period April 1, 1992 through April 1, 1993. Obviously, the surcharges have a significant impact on ERISA plans operating in the State of New York.

WHEREFORE, it is respectfully submitted that The Travelers motion for summary judgment should be granted.

ROBERT A. SUJECKI

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Jerry Weissman, filed February 8, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

JERRY WEISSMAN, being duly sworn deposes and says:

1. I am the Chief Financial Officer of Empire Blue Cross and Blue Shield. I execute this affidavit in support of the New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield's motions for a stay in these actions pending appeal.

2. Familiarity of this Court with the background information on the New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield, as well as the operation of these Plans as health services corporations, is assumed. *See* Affidavits of Antonini in Support of Cross-Motion for Summary Judgment ¶¶3-6; Weissman ¶¶18-23 and Reply Weissman Affidavit ¶¶3-8. Familiarity with the statutes at issue is also assumed.

DEFENDANTS WILL BE IRREPARABLY HARMED IF THE ORDER IS NOT STAYED

3. As set forth in the submission of the State, the Blue Cross and Blue Shield Plans, and the hospitals in support of their cross-motions for summary judgment, the differentials are integral

parts of the $20 billion hospital inpatient rate setting scheme in New York and these parties will be significantly harmed if the 13% differential is immediately enjoined. Moreover, loss of the differential will have an adverse impact on the continuance of the Blue Cross and Blue Shield community pools with potentially devastating consequences to the people of this State.

A. *Harmful Disruption of the Hospital Reimbursement System*

4. In actuality, and as recognized by this Court at pages 19-20 of the Opinion and Order, the potential ramification of this Court's decision is extremely broad and calls into question New York State's efforts to regulate and control hospital costs. The defendants have contended, in fact, that the Plaintiffs in these actions have actually challenged the right of the Legislature to establish a comprehensive reimbursement system that determines the reimbursement rates of all payors and controls the costs of hospitals.

5. It is beyond question that disruption of the integrated reimbursement methodology through the loss of the differential will necessarily adversely affect hospital financial stability which is one of the primary goals of the NYPHRM system.

6. Because all payors and all the hospitals have been operating under the NYPHRM system for more than a decade, it is extremely harmful and prejudicial for the system to be discarded overnight. While the appeals on these issues are pending, the *status quo* should be maintained to avoid confusion and disruption of the health care delivery system which has already commenced since this Court rendered its decision.

7. For example, since the decision, serious questions have been raised as to whether payors must continue to pay all other components of the state certified rate, without the differentials or whether payors have the option to pay charges or negotiated rates

in lieu of the state certified rates. This has caused and will cause chaos and confusion in the health care delivery system, as well as in the insurance marketplace.

8. If the differential is eventually held to be preempted by ERISA upon appeal, precious time to consider reimbursement alternatives will have been gained by a stay of this Court's decision. In such a manner, further exacerbation of hospital financial problems can be avoided which is obviously in the public's interest.

9. It also must be noted that if the Plans can no longer benefit from the differential in hospital reimbursement rates paid by payors, the Plans must consider making significant changes in the manner in which the Plans promote hospital financial stability. *See* Weissman Affidavit in Support of Motion for Summary Judgment ¶40. Whether advance payments in the amount of $300 million can continue under a system without the differential is under consideration. Loss of advance payments would be disastrous to hospitals.

10. Recognition of the broad ramifications of this decision, as this Court has done, should lead the Court to conclude that maintenance of the present highly integrated health and insurance systems, including the differential, is necessary for a time during the pendency of the appeal.

11. The loss of the differential as part of hospitals' reimbursement will cause grave, immediate, financial consequences for the hospitals and will affect the Plans' subscribers ability to obtain access to quality medical care as loss of the differential will undoubtedly affect the level of services provided by hospitals. The hospitals will lose approximately $160 million in operating income that they were entitled to receive under the current NYPHRM system which does not expire until the end of this year.

See Sisto Affidavit in Support of Cross-Motion for Summary Judgment, ¶¶39-42.

B. *Direct Impact on Plans' Ability to Continue to Spread Risk*

12. In the Opinion and Order, the Court found that the payment of the differentials by commercial insurers increases the numbers of good risks in the Blue Cross and Blue Shield pools, thereby providing for the spreading of high risk individuals among a larger pool. Opinion and Order, page 23.

13. Encouraging the spreading of risks is an extremely important function of the differentials. Without the 13% differential, the Plans, their subscribers and the people of the State of New York will be irreparably harmed, especially in light of the fact that no replacement system is available at present.

14. As noted by the Deputy Superintendent of Insurance James Clyne:

> [i]f the differentials are eliminated or reduced, the Blue Cross Plans would not be in a position to make coverage available to those least able to obtain it and the government, through tax monies, would become the insurers of last resort through Medicaid or by subsidizing hospitals directly.

Clyne Affidavit ¶9.

15. Deputy Superintendent Clyne also described the spiraling effect the loss of good risks to commercial insurers offering lower premiums has on the Plans community rated pools—as good risks leave, the community pools dwindle resulting in higher premiums for the remaining subscribers. This cycle, he explained, is offset through the differentials which restore "some measure of equality" to the insurance market-place by making

Blue Cross more attractive to good risk groups seeking lower payments to hospitals.

> Were it not for differentials, the inability to attract good risk customers would result in a smaller and smaller risk pool, comprised of predominantly poorer risks causing higher premium rates and deterioration of a viable health insurance system.

Clyne Affidavit ¶19.

16. There is uncontroverted proof in the record that a large percentage of the groups which leave the Plans' pools are good risk groups which leave to obtain commercial coverage at a lower premium. *See* Reply Affidavit of Weissman at ¶¶13-15.

17. If during the pendency of the appeals in these actions, the commercial insurers are no longer required to pay the differentials, the commercial insurers' ability to cherrypick good risks from the Plans' pools is greatly enhanced.

18. In fact, since Chapter 501 of the Law of 1992 was enacted, cherry picking has accelerated. *See* Weissman Reply Affidavit in Support of Cross-Motion for Summary Judgment ¶¶17-18. There is an ever increasing percentage of high risks in the community rated pools than ever before which will require premiums to continue to be increased at higher rates to avoid huge losses.

19. On January 1, 1993, Empire was granted an overall weighted average increase of 25.5% on its community rated contracts. Even with the increase, Empire projects that it will lose *$143,000,000* on these contracts during 1993. A copy of a portion of the Superintendent's Opinion and Decision granting the increase is attached hereto. The losses on these contracts will greatly increase without the differentials in hospital reimbursement rates as greater numbers of good risks leave to obtain

coverage from commercial insurers which are no longer required to pay higher hospital rates, according to the Court's decision.

20. The existence of the community rated pools of the Plans, containing an ever increasing number of high risk subscribers, are directly threatened by the loss of the differential as recognized by the Insurance Department. This would directly result in higher numbers of uninsured in New York State. *See* Weissman Affidavit in Support of Motion for Summary Judgment ¶38.

21. The impact the loss of the differential will have on the Plans' business other than on community rated contracts cannot be understated. The Plans compete with commercial insurers in the large group market so that the rates on these contracts can subsidize the community rated contracts. This permits the community rated coverage to be offered at an affordable rate. Without the differentials, the Plans' ability to compete in the large group market will be adversely affected threatening the subsidies provided to the community rated subscribers and the affordability of rates, thereby potentially increasing the risk of pricing insurance out of reach for many more individuals and Medicare supplementary coverage subscribers. *See* Reply Affidavit of Weissman, ¶¶6-8.

22. It is in the public interest and in the interest of the Plans and the hospitals to allow the current system to operate during the pendency of this appeal.

C. *Harm to the Commercial Insurers*

23. In contrast to the overwhelming disruption and harm caused to the Defendants if a stay is not granted, the Plaintiffs would simply be required to pay a differential, as they have been doing for a decade. If the Plaintiffs are successful on appeal, adjustments to future hospital rates paid by the commercial insurers could be simply made.

24. The Plaintiffs harm is clearly outweighed by the harm which will be caused by the immediate disruption of the operation of the health care and insurance systems if a stay is not granted.

WHEREFORE, the Intervenors respectfully request a stay of this Court's Opinion and Order during the pendency of the appeals in this action.

JERRY WEISSMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Daniel Sisto, filed _____

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Daniel Sisto, being duly sworn, deposes and says:

1. I am President of the Intervenor Hospital Association of New York State ("HANYS"). In this capacity, I am required to be fully familiar with the operation and circumstances of hospitals throughout New York State, including the importance to them of the 13% differential as operating income and the consequences of its loss. This Affidavit is submitted in support of HANYS' motion for a stay of this Court's Order of February 3, 1993 enjoining the enforcement of the 13% differential.

2. My knowledge of the consequences that will befall hospitals throughout the State is derived from a number of sources. First, HANYS regularly collects financial data from each of its member hospitals. This information is continuously analyzed by HANYS staff and reviewed by me and other HANYS management on an ongoing basis. Second, many studies by outside agencies and experts on the financial condition of hospitals are prepared every year. These are also collected and reviewed by myself and HANYS staff. Third, as president of HANYS, I meet or speak virtually daily with the Chief Executive Officers and Chief Financial Officers of our member hospitals, during which the financial difficulties and circumstances of hospitals are reviewed.

These can be formal meetings such as Board of Trustees meetings or sessions of the Council on Health Care Financing, or informal communications such as telephone conversations wherein hospital executives relate to me the consequences of events, such as the invalidation of the 13% assessment.

3. While the Court may be accustomed to reading what it considers to be hyperbole by parties claiming irreparable injury, I assure the Court that it is very difficult to overstate the harm that will be caused to hospitals and the public by a loss of the revenues from the 13% differential for even the briefest period. For 1991, the last year for which complete data is available, the 13% differential accounted for approximately $160 million in operating income to hospitals statewide. The best estimates for the current impact of the 13% differential is about $200 million. The precipitous removal of this revenue source, before the appeal can be heard or the Legislature can attempt a reconfiguration of the hospital inpatient reimbursement system, will cause serious and irreparable injury to hospitals and the consuming public.

What we can expect to see very shortly would include hospital defaults on mortgage payments, cancellation of plans for purchase of state-of-the-art equipment and capital construction or renovation projects, breach of collective bargaining agreements, large-scale layoffs, closure of hospital programs and services, the simple inability to meet hospital short-term financial obligations, and, as a result, a serious decline in the availability of hospital services of the highest quality.

THE FINANCIAL CONDITION OF NEW YORK STATE HOSPITALS

4. As mentioned previously, numerous studies have been made of the financial condition of New York State's hospitals by HANYS, as well as by independent examiners. Those studies have consistently concluded that New York's hospitals experi-

ence dangerously low operating margins and a financial condition which is very weak, both from an objective standpoint and relative to hospitals across the United States. Rather than just cite a few individual instances of harm that particular hospitals will suffer, in order to avoid any suggestion that such claims are aberrational or merely anecdotal, I will relate the findings of two recent independent studies which confirm on a system-wide basis our hospitals' deteriorating and perilous financial condition.

5. Health Care Investment Analysts, Inc. (HCIA) recently conducted a study of the financial condition of New York's hospitals. HCIA is a nationally-recognized source for health care information and conducts numerous studies both for government and private associations. HCIA's database is probably the most extensive in the country and its analytical membership consists of members of the Johns Hopkins University faculty. HCIA analyzed various statistical indicators to arrive at certain conclusions regarding the economic condition of the hospital system in New York as of the end of 1991. A copy of the HCIA study has already been forwarded to the Court and the parties.

6. HCIA observed that "[b]ecause hospital inpatient reimbursement for all payers (Medicare, Medicaid, Blue Cross, Commercial Insurers, and Self-Pay) is regulated by either the State or Federal governments of New York, the financial health of New York hospitals is significantly affected by changes in public policy. Thus, players in the industry must be aware of the financial condition of New York hospitals and be sensitive to the relationship of policy to the fiscal viability of hospitals," (HCIA study, p.9). This observation is particularly relevant to the matter at hand, since elimination of the 13% differential, due to ERISA preemption, amounts to a major deviation in policy that will withdraw an estimated $200 million from our hospitals.

7. Using an analysis of 21 selected indicators of financial and operating performance, HCIA grouped hospitals into one of four

classifications: Critical, Poor, Adequate, and Good. The "Good" rating is considered investment grade, and it is expected that hospitals in the "Good" category should be able to raise debt financed capital based on their historical performance. The "Adequate" category consists of hospitals which may, under some circumstances, be able to raise debt finance capital, while those in the "Poor" category are those in which performance has deteriorated more rapidly than expected during the last 5 years. Finally, those in the "Critical" category are those in the most desperate financial condition and are on the verge of bankruptcy or closure without a substantial infusion of external support. (HCIA study, p.3).

8. The HCIA study shows that 53% of New York's nonprofit hospitals are either in the "Critical" or "Poor" categories, 42% are in the "Adequate" category, and only 5% are considered "Good." (HCIA study, p.4). In the New York City area, among the non-teaching hospitals (those which do not have interns and residents), 37% were in "Critical" condition, 37% were in "Poor" condition, only 26% were considered "Adequate," and none were "Good." Similarly, teaching hospitals in the downstate area showed 22% in "Critical" condition, 43% in "Poor" condition, 27% deemed "Adequate," and 8% labeled as "Good." Statewide, of the six groupings of hospitals used for reimbursement purposes, four of the six peer groups experience serious financial hardships, with well over half of all of the facilities in these four groups classified as being in either "Poor" or "Critical" condition. (HCIA study, p.5).

9. The HCIA study also observed that New York hospitals placed 49th out of 51 states (including the District of Columbia) in terms of operating profitability, a position unchanged from 1987.(HCIA study, p.8) HCIA further concludes that since its previous study three years ago, the overall performance of New York's nonprofit hospitals has continued to deteriorate, with the

number of hospitals classified as "Poor" or Critical" increasing substantially since 1988. (HCIA study, p.9).

10. A second study was recently conducted by William O. Cleverley, Ph.D., CPA. Dr. Cleverley is a Professor at Ohio State University, is an acknowledged expert in hospital reimbursement matters, and is a frequent publisher of studies of various states' hospital reimbursement performance. Dr. Cleverley's report, which has also been provided to the Court and the parties, examined financial information for nearly all New York State hospitals for the period 1989 through 1991 and compared New York State hospital performance with that of hospitals across the country. Four basic financial concepts were analyzed to measure the strength of hospital performance; profitability, liquidity, debt capacity, and condition of physical facilities. The general conclusion of the report is that

> the overall financial condition of NYS hospitals is very weak when compared to U.S. hospital industry averages and to generally accepted standards of financial performance. Without substantial improvement in NYS hospital financial performance in the near future it is our opinion that many NYS hospitals will face severe financial problems with the possibility of significant increases in closure and bankruptcies. It is also very likely that the physical and technological condition of hospital plant facilities will deteriorate in NYS, making many NYS hospitals substandard providers of health care services relative to U.S. hospital standards. (Cleverley study, p.2).

Significant among Dr. Cleverley's general observations is that expectations regarding hospital payments over the next few years are almost universally negative as government and major private payors seek to reduce their health care expenditures. He concludes; "With the already weakened financial position of many

NYS hospitals, the resulting shock could prove fatal to many hospitals in NYS." (Cleverley study, p.3).

11. I will not prolong this Affidavit with a detailed explanation of all of Dr. Cleverley's findings. However, I believe it is important to highlight one aspect of his study which is of more immediate concern and particular relevance to the matter at issue. This is with regard to short-term liquidity of our hospitals.

Dr. Cleverley uses two typical financial ratios to measure liquidity:

1. Current (CUR) Ratio; and

2. Days Cash on Hand (DCOH) Ratio.

CUR ratios for New York State hospitals are very low when compared to United States hospital medians. The median New York State CUR ratio in 1991 was 1.19 compared to the U.S. hospital median of 2.00. According to Dr. Cleverley, no New York State group of hospitals has a median that matches the U.S. median, and several groups are less than 1.0. A current ratio less than 1.0 means that the hospital does not have enough short-term cash and receivables, as well as other designated current assets, to meet obligations that will be due in the very near future. More than 25% of all New York State hospitals were in this situation at the end of 1991, according to Dr. Cleverley's report. (Cleverley study, p.10).

12. As to cash on hand (the DCOH ratio), median values for New York State hospitals are also very low. In 1991, the median DCOH across New York was 13.6 days, compared to an all U.S. median of 19.6 days. Dr. Cleverley indicates that "[t]hese lower values would be of less concern if NYS hospitals had sufficient amounts of long term reserves available to meet short term needs should an unexpected event take place, but this is not the case."

(Cleverley study, p.10). Dr. Cleverley notes that long-term reserves of New York State hospitals are very low and thus are not available to meet short-term needs to meet an unexpected event. The "unexpected event"—elimination of $200 million in revenue—has occurred and our hospitals do not have the cash or long-term reserves to cushion this blow. Even more extraordinary than the median 13.6 DCOH is the study's report that New York City hospitals are in a very dangerous position, with more than 25% of all hospitals in the New York City area having fewer than 5 days cash on hand. (Cleverley study, p.10).

A hospital with so little available cash is, quite frankly, in desperate need of continuously flowing dollars. Cash on hand is what funds employee payrolls and pays suppliers of services. In a service-intensive sector such as hospital care, a missed payroll is an invitation to disaster. Unpaid staff do not, under any circumstances, provide optimal patient care. Without the continued flow of the differential dollars, hospitals' ability to maintain service continuity, especially in those areas where severe cash shortages are widespread, is directly and immediately jeopardized.

13. Had this information from the HCIA and Cleverley studies emanated solely from HANYS, it might be dismissed as self-serving aggrandizement. The studies and conclusions, however, have come from national experts on hospital financing who have consistently reported the precarious condition of hospitals across the State. Unfortunately, final data after 1991 is not currently available, but the consistent trends indicate that the precarious state of our hospitals is continuing unabated. With extremely low and negative operating margins, extraordinarily high debt ratios and a precarious cash-on-hand situation, the harm to cash flow caused by the immediate removal of $200 million in operating income will substantially disrupt hospital operations, both short-term and long-term.

REVENUE FROM THE DIFFERENTIAL IS NEEDED TO MAINTAIN CURRENT OBLIGATIONS

14. Hospital financial and contractual commitments exert a constantly upward pressure on hospital costs, at a time when financial stability is most fragile. It is obvious that hospitals require continued operating revenues in order to maintain services and it is further obvious that any diminution in revenues, given the financial fragility of New York's hospitals, has the very real potential of seriously disrupting operations.

15. For example, hospitals, like many other service enterprises, have a high percentage of their expenses dedicated to employee salaries. For a large number of hospital employees, particularly in the downstate sector of the State, employee salaries are collectively negotiated in long-term contracts. By necessity, these negotiations and resulting collective bargaining agreements are premised on projections of expected revenues which will be sufficient to cover agreed-upon salary and fringe benefit increases.

16. In 1992 in particular, a major contract was negotiated between approximately 30 hospitals in the New York City area and the union representing about 38,000 non-professional hospital employees, such as laundry workers, housekeepers, nurses aids, secretaries, laboratory technicians, dieticians, and respiratory therapists. The terms of the contract cover a 3-year period from mid-1992 through mid-1995. For each year, there are salary and fringe benefit increases. The contract calls for an increase in 1993, which on average amounts to some $2,000 per employee, for a total of about $78 million. This sum is an increase over the percentage increase in 1992 and will be followed by an additional increase in 1994. These binding salary obligations were obviously reached on the expectation by the hospitals that revenues would be sufficient to cover the increased contract costs, based upon continuation of present revenue sources. While the 13%

differential will not provide all the revenue to support the contract increases, loss of this revenue will jeopardize or preclude these hospitals' ability to fulfill their contract obligations.

17. This problem relates not just to regional collective bargaining agreements or to non-professional employees. Many other contracts, more typically negotiated on a hospital-by-hospital basis, apply specifically to registered professional nurses, of which there is a tremendous shortage. In the case of professional nurses, negotiated agreements have resulted in percentage increases which in general have exceeded those for non-professional employees. Furthermore, this phenomenon does not exist solely in the New York City area, but is experienced by all hospitals throughout the State. Hospitals are contractually bound to pay employees according to the contract terms and on regular paydays. The inability to meet these commitments will result in more than just labor strife. These professionals, who are in critically scarce supply, will simply leave the hospital or the State for better job stability elsewhere. The revenues derived from the 13% assessment are required in order for hospitals to be able to attract and retain adequate numbers of employees so that services to patients continue uninterrupted.

As I previously acknowledged, the revenues from the 13% differential are not the sole source for supporting employee salary requirements, but certainly the daily cash flow from the $200 million is essential to almost every hospital's ability to make payroll. Without the $200 million or an alternative source immediately available to make up for this loss of funds, the provision of hospital services will no doubt suffer.

18. Another problem of equal magnitude that will be caused by the loss of the 13% differential will be the inability of hospitals to make mortgage payments. As the HCIA study indicates, the investment quality of New York hospitals is already precariously low and the prospect of removing a significant portion of

expected revenues will undoubtedly trigger foreclosures. Due to the already acknowledged difficulty of New York hospitals' ability to make mortgage payments on construction projects, the federal Department of Housing and Urban Development is seriously considering closing the New York market for its FHA insurance program. This is particularly troublesome since the vast majority of hospital construction projects are now FHA insured because the conventional market is for all intents and purposes inaccessible to New York hospitals.

19. In addition to collective bargaining agreements and mortgage obligations, there are a myriad of day-to-day operational demands which consume resources that must be supported by adequate daily revenues. These day-to-day operational demands have a direct bearing on patient care. The purchase of supplies and equipment; waste disposal; the purchase of vaccines and the continuation of immunization programs for childhood disease; the need to address the huge and increasing demands to treat the epidemics of tuberculosis, AIDS, substance abuse and mental illness all require that sufficient revenues be in place.

20. Ultimately, it is the public at large that will suffer the most from immediate loss of the 13% differential. When a workforce is reduced, or fewer supplies are purchased, or construction is stalled, then patient care is affected. This affects all patients, including the plaintiffs' insureds or beneficiaries. This is not a consequence that can be fixed at some later time, because the patient who receives inadequate care today cannot be "compensated" by better care tomorrow when the system has stabilized. Thus, should the differential be eliminated with no opportunity for an alternative to be developed, irreparable harm will befall not just the hospitals, but also the consuming public.

The Court can be assured that wholesale patient care disruption will be avoided whenever possible, since direct patient service reductions is a solution of last resort. This result is unavoidable,

however, in those hospitals which are already at the breaking point. What will uniformly occur will be a less measurable, but equally insidious phenomenon. Staffing will be shaved—not completely eliminated—in certain clinical units or hours in outreach clinics will be reduced or appointments canceled and rescheduled for weeks later. Patients' chronic conditions will worsen; long waits for the overtaxed floor nurse will get even longer; laboratory results will arrive a day later. Cumulatively, the quality of care across the system will degenerate. The immediate removal of the differential funds hastens the degeneration because, across the State's hospital system, there are not reserves to substitute for these revenues.

21. In order to measure the impact of the immediate loss of the 13% differential in practical terms, my staff contacted two hospitals, one downstate (Brookdale Hospital Medical Center) and one upstate (Ellis Hospital). The Brookdale Hospital Medical Center is a 796 bed hospital in Brooklyn. Brookdale serves a heterogeneous patient population which includes significant numbers of patients enrolled in employee benefit plans. The Medical Center is also categorized by New York State as a "financially distressed" hospital, meaning that its financial condition is especially precarious and that it is a crucially needed source of health care in the community.

Virtually all of Brookdale's employees—nurses, therapists, technicians, clerks, etc.—are unionized and covered by an existing collective bargaining agreement. That agreement requires the hospital to make designated contributions to its employees' health and welfare benefit fund. It is my understanding that immediate removal of the 13% differential revenue is likely to cause the Medical Center to fall into delinquency on its payment obligations. In addition, I also understand that without the revenue specifically attributable to the 13% differential, the Medical Center may be unable to make the next required payment of its hospital malpractice insurance premium. This raises the startling

prospect of the hospital's loss of insurance coverage which, even if this were to occur for some limited time period, would expose it to severe liability risks.

22. Ellis Hospital is a 352-bed hospital located in Schenectady. In 1992, Ellis suffered operating losses of over $6 million. By restructuring management, laying off workers, and eliminating job positions, the Hospital's budget for 1993 is at break-even. Ellis' patients include a sizeable number covered by employee benefit plans, and Ellis derives over $550,000 from the 13% differential alone. Thus, the loss of the differential would bring the hospital back into an operating deficit situation. The $550,000 in revenue supports about 20 full-time equivalent positions at Ellis. I am advised that the hospital has not reached a conclusion regarding how the loss would be apportioned, but a variety of measures are under consideration. These include limiting or eliminating the operation of outreach clinics in the City of Schenectady and outlying areas of Schenectady County, reducing the hospital's outpatient mental health program and reducing its inpatient psychiatric program. Due to prior years' revenue shortfalls, Ellis has already been forced to discontinue its alcoholism program and its poison control program. I understand that in a typical year, the hospital considers $4 million in requests for new equipment, yet normally is only able to afford about $1 million in new purchases. A further revenue loss would mean even less availability of more sophisticated diagnostic and treatment equipment.

With regard to medical supplies for hospitalized inpatients, such as drugs, Ellis is presented with a very common dilemma. The drug of choice by physicians for the early stages of heart attack is TPA. TPA costs about $2,200 per dose. The expected 1993 cost to Ellis of TPA alone is about $270,000. The revenue needed to purchase the drug is at least in part derived from the differential.

With a budget at break-even, the $550,000 loss in 13% differential revenue will, I believe, directly affect patient care at Ellis. I cannot predict exactly where or how the impact will be felt—whether by a combination of reduced clinic hours, elimination of some psychiatric beds or unavailability of the preferred heart attack medicine or more drastic cuts in just one area—but the hospital, staffed as it is, must as a last resort look to patient care services for cuts.

23. I do not suggest that the 13% differential should be extended indefinitely despite the Court's February 3 holding. I do respectfully represent, however, that it is vitally important that the differential not be precipitously eliminated without the chance for one of two things to occur: either that the Second Circuit have the opportunity to review this Decision or that the State Legislature have the opportunity to restructure the system for hospital reimbursement to account for the voiding of the differential. Neither of those events can occur immediately. The issue is not solely a matter of losing funds; it is also the quality and extent of hospital care throughout the State. Our all-payor regulated reimbursement system cannot, as it is now constructed, be administratively adjusted to accommodate this Court's decision immediately. We simply ask that the Court recognize this reality and allow for some period of time for either appellate review of this matter or some other action to be taken to address the serious and far-reaching consequences of the Court's decision. I respectfully urge that the Court consider the real and difficult circumstances which are arising immediately and provide hospitals with the requested relief, therefore minimizing the disruption and damage to the hospital system and to our patients.

DANIEL SISTO

[Jurat omitted in printing.]

IN THE
UNITED STATES DISTRICT COURT FOR THE
SOUTHERN DISTRICT OF NEW YORK

Affidavit of Timothy F. Lyons, filed February 9, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

TIMOTHY F. LYONS, being duly sworn, deposes and says:

1. I am employed by plaintiff The Travelers Insurance Company ("The Travelers") as Counsel in the Law Department of The Travelers. I have been responsible for overseeing this lawsuit since it was commenced in June of last year.

2. I submit this affidavit in opposition to the Defendents' and Intervenors' motions for a stay of the injunction which this Court entered on February 3, 1993. In this affidavit, I specifically address the issues relating to the 11% surcharge and the 13% surcharge. Although I believe the same logic applies to the 9% surcharge, I do not address that matter in this affidavit since The Travelers Insurance Company did not assert a claim as to the 9% surcharge.

THE 11% SURCHARGE

3. I would like to first turn my attention to the 11% surcharge. This surcharge was enacted as part of New York's Omnibus Revenue Act of 1992, effective April 1, 1992, for a one-year period in order to balance New York State's budget. By law, the 11% surcharge will expire on March 31, 1993.

4. Since the 11% surcharge was first enacted in April 1992, The Travelers has segregated the funds relating to the 11% surcharge. The Travelers' reason for doing this is simple: Upon analysis of the statute, The Travelers realized that if it paid the surcharge, it would never be able to recover the amounts at issue even if it prevailed on its legal challenge to the surcharge. In essence, the statute requires The Travelers to pay the 11% surcharge to the hospital rendering the service, which in turn, must pay the funds at issue over to New York State. Thus, for The Travelers to recover the amounts at issue, The Travelers would have to bring lawsuits against each of the approximately 260 hospitals operating in New York State. Of the approximately $9.1 million which The Travelers anticipated paying as a result of the surcharge, this would result in an average claim against each hospital of approximately $35,000. Inevitably, in such lawsuits, the hospitals would defend on the grounds that The Travelers had voluntarily paid the amounts at issue, and that The Travelers should seek recovery from New York State, the ultimate recipient of the funds at issue. (The State, of course, maintains that The Travelers' remedy is against each individual hospital (The State Defendents' Memorandum in Support of a Stay at 7).) Even if The Travelers could overcome these defenses, The Travelers would then have to enforce judgments against 260 separate hospitals. Given the cost of such a sweeping litigation program, and the difficulties of enforcing a money judgment against a hospital, The Travelers recognized that unless it withheld all funds relating to the 11% surcharge, its challenge to the statute would be futile.

5. The same is true today. If The Travelers were now compelled to pay the 11% surcharge, there would be no practical way for it to ever recover the monies at issue. In other words, The Travelers would be irreparably injured if it had to pay the 11% surcharge. The State, of course, faces no such injury. If this Court denies the motion for a stay, The Travelers will continue to segregate all amounts relating to the 11% surcharge. In the unlikely event this Court's decision is reversed and the 11% surcharge is upheld, The Travelers will turn the funds at issue over to the State. Thus, if the surcharge is upheld, the State will be able to immediately recover the funds at issue. However, if The Travelers now pays the amounts at issue, and Defendants or Intervenors do not obtain a reversal of this Court's ruling on the 11% surcharge, The Travelers would not be able to recover the amounts at issue.

6. In closing my discussion of the 11% surcharge, I note that I am quite surprised by the State's claim that it will be irreparably injured if this Court enjoins the enforcement of the 11% surcharge. In the ten months since the enactment of the 11% surcharge, the State has done absolutely nothing to enforce the surcharge. In fact, the State has never even contacted The Travelers Insurance Company and requested that the 11% surcharge be paid. In light of the State's acquiescence in our withholding of the 11% surcharge and the fact that the 11% surcharge will expire on March 31, 1993, it is hard to imagine how the State will be irreparably injured if the surcharge is not enforced for the remaining seven weeks of its life.

THE 13% SURCHARGE

7. Unlike the 11% surcharge, the 13% surcharge has been in place for several years. Although The Travelers recognized at the time it commenced this litigation that recovery of amounts paid pursuant to the 13% surcharge would also be unlikely for the reasons discussed with regard to the 11% surcharge, The Travelers did not want to disrupt the functioning of New York's hospital system before obtaining a ruling on the legality of the 13% surcharge. Therefore, it continued to pay the 13% surcharge during the pendency of this litigation in order to give the State an opportunity to make alternative plans for the funding of New York's hospital system should this Court determine, as it has, that the 13% surcharge is invalid under ERISA.

8. The 13% surcharge applies in the case of both self-insured and fully insured ERISA plans. With regard to the 4,338 ERISA plans as to which The Travelers provides health insurance, The Travelers estimates that it has paid $7.2 million as a result of the 13% surcharge since this lawsuit was commenced in June 1992. As explained in the Gutterman and Sujecki affidavits submitted in support of The Travelers' motion for summary judgment, the 13% surcharge is reflected in the premiums charged by The Travelers.

9. Since this lawsuit was commenced in June 1992, the 91 self-insured ERISA plans with regard to which The Travelers provides administrative services have paid approximately $8.6 million as a result of the 13% surcharge. In sum, as a result of the 13% surcharge, The Travelers has paid a total of approximately $15.8 million on behalf of 4,429 ERISA plans since this lawsuit was commenced in June 1992.

10. The total cost of the 13% surcharge for the plans at issue is approximately $2.0 million per month. I understand that it would normally take approximately eight months for the briefing, argument and decision of an appeal of a case such as this one. Thus, if this Court were to stay its injunction pending appeal, the ERISA plans at issue would probably pay an additional $16.0 million pursuant to the 13% surcharge. It would simply be unfair to ask the ERISA plans to bear this burden in light of the fact that there is no practical way for the plans to recover the funds at issue.

11. The Travelers fully understands the need to finance New York's hospital system. However, ERISA plans operating in New York State should not be asked to continue to subsidize the hospital system at the rate of two million dollars a month through an unfair surcharge which this Court has determined to be illegal under ERISA. This is particularly true since those plans have already paid approximately $15.8 million since this litigation was commenced.

12. In this regard, I note that The Travelers is not even in a position to continue paying the surcharge with regard to its self-insured ERISA customers. Under ERISA, the plan sponsors, trustees or other appropriate fiduciaries have an obligation to use plan funds only for the benefit of plan participants and beneficiaries. Recognizing the serious legal issues raised by the 13% surcharge, it is extremely likely that the plan sponsors, trustees or other appropriate fiduciaries of many of the self-insured plans will simply refuse to continue to pay the 13% surcharge. This, in fact, has already occurred with regard to two self-insured plans. In late 1992, The Travelers was informed by representatives of the two self-insured plans at issue that the plans had determined that the 13% surcharge was illegal under ERISA. The Travelers was, therefore, instructed not to use any plan assets to pay the 13% surcharge. Clearly, ERISA plans have felt the burden of the 13% surcharge and feel they cannot continue to pay the surcharge.

13. In light of this Court's determination that the 13% surcharge is illegal under ERISA, and the inability of either The Travelers or an ERISA plan to recover funds paid pursuant to the 13% surcharge, this Court should not stay its order enjoining enforcement of the 13% surcharge. During the pendency of an appeal from this Court's February 3, 1993 order, The Travelers will segregate the funds relating to the 13% surcharge in connection with its fully insured ERISA customers. The Travelers will also recommend that its self-insured ERISA customers do likewise. Thus, in the unlikely event that this Court's decision is reversed and the 13% surcharge is upheld, the funds will be readily available for payment to the hospitals. This will leave the hospitals with an easy mechanism to recover the funds at issue. In closing, I note that none of the Defendants or Intervenors have proffered any kind of similar mechanism for the reimbursement of the funds relating to the 11% surcharge or the 13% surcharge to The Travelers or the ERISA plans at issue.

WHEREFORE, the defendants' motion to stay the injunction entered by this Court on February 3, 1993 should be denied.

TIMOTHY F. LYONS

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Steven C. Anderman, filed
February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STEVEN C. ANDERMAN, being duly sworn, deposes and says:

1. I am a Deputy Director of the Office of Health Systems Management ("OHSM"), New York State Department of Health ("Department"). I have supervisory responsibility over OHSM's Division of Health Care Financing, including the hospital reimbursement rate setting process, and I am accordingly familiar with the facts hereinafter set forth. I make this affidavit in support of defendants' application for a stay of Judge Freeh's decision and order of February 3, 1993 in the instant case, pending defendants' appeal of said decision and order to the Circuit Court of Appeals for the Second Circuit.

2. Judge Freeh's decision largely invalidated three provisions of §2807-c of the New York Public Health Law ("NYPHL"): (a) the 13% differential hospitals are generally required to apply to the inpatient hospital bills of patients covered by third party payors other than Medicare, Medicaid, health maintenance organizations ("HMO's"), and/or Blue Cross plans (NYPHL §2807-c(1(b)), (b) the additional 11% differential hospitals are required to bill for patients covered by commercial health insurance carriers (NYPHL §2807-c(11)(i)), and, (c) the contingent variable differential (0% to 9%) applicable to patients covered by HMO's

(NYPHL §2807-c(2-a)). This affidavit will address the issue of the 13% differential, the abrupt invalidation of which will have a significantly disruptive effect on New York's system for financing hospital inpatient care. It is therefore respectfully submitted that, under these circumstances, a stay pending appeal of the Court's decision and order is warranted.

3. There are approximately 260 hospitals in New York, annually providing over 21 million days of inpatient care. Virtually all of the revenue these hospitals receive for inpatient care, with the exception of Medicare reimbursement, is regulated pursuant to NYPHL §2807-c. The reimbursement system reflected in this statute is highly integrated and is carefully designed to achieve the critical policy goals of assuring access to high quality hospital care, maintaining hospital fiscal integrity and promoting efficiency and cost containment.

4. The 13% differential is an important element in this integrated reimbursement system. It provides significant revenue to hospitals and is of critical importance in maintaining the competitive viability of the Blue Cross system. The hospital reimbursement and health insurance system cannot long function in its current form without the 13% differential. Therefore, the State will have to revise the hospital reimbursement system in some fashion as a result of this Court's decision and order.

5. The invalidation of the 13% differential will reduce hospital revenue by approximately $200 million a year. Virtually every hospital in New York will be affected. There is no methodology currently in place which would permit the hospitals to replace this revenue. The abrupt and unplanned for loss of $200 million in inpatient revenue will have a disruptive impact on the hospital system. It is essential that hospitals and the State hospital regulatory system have sufficient time to properly evaluate the impact of this alteration of a significant element of the hospital reimbursement system and to consider what adjustments in the system

will be required. A stay pending appeal will permit such an evaluation to be conducted in a reasoned, deliberate manner. Absent that, any such evaluation and adjustment will necessarily have to be accomplished in haste, in an atmosphere of crisis that will not be conducive to the proper operation of a critical public resource.

6. The abrupt invalidation of the above-described provisions of NYPHL §2807-c will risk provoking a major crisis in the hospital system which the people of this state depend on for medical care. It is essential that if adjustments must be made in a health care system this large and complex sufficient time must be afforded to intelligently design the necessary changes.

WHEREFORE, it is respectfully submitted that defendants' application for a stay pending appeal of the Court's decision and order February 3, 1993 should be granted in all respects.

STEVEN C. ANDERMAN

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Stuart L. Lefkowich, filed February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

STUART L. LEFKOWICH, being duly sworn, deposes and says:

1. I am employed by the New York State Department of Social Services (Department) in the position of Assistant Commissioner. I serve as Director of the Bureau of Primary Care, Division of Health and Long Term Care. I am responsible for policy implementation relating to health maintenance organizations (HMO's) and managed care in the Medical Assistance (Medicaid) Program, established pursuant to Title 11 of Article 5 of the Social Services Law (SSL), Chapter 55 of the Consolidated Laws of New York.

2. I make this affidavit in support of Defendants' application for stay of the Court's order in this action.

3. In a previous affidavit in this action, sworn to September 30, 1992, I described in detail the joint federal-state Medicaid Program, the role of the Department in supervising administration of Medicaid, the provisions of federal and State law authorizing participation of HMO's and inclusion of managed care programs in Medicaid, the significance of HMO's and managed care in improving quality, continuity and comprehensiveness of health services under Medicaid, ant the important effect of the 9%

factor, imposed effective April 2, 1992 by subdivision 2-a of Section 2807-c of the Public Health Law upon rates of payment to general hospitals for reimbursement of inpatient hospital services furnished to subscribers of HMO's, as an incentive to HMO's to participate as managed care providers in the Medicaid program. Please refer to my earlier affidavit for a full exposition of these matters.

4. A significant increase in the number of HMO's participating in Medicaid was seen in 1992, the year of enactment of subdivision 2-a. In 1991, there were 13 HMO's with Medicaid contracts while in 1992, to the date of my earlier affidavit, 23 HMO's had Medicaid contracts.

5. Analysis of data becoming available in the months subsequent to my earlier affidavit demonstrates a more striking correlation between the effective period of subdivision 2-a and increased HMO participation in Medicaid. On April 1, 1992, immediately preceding the effective date of subdivision 2-a, there were 24 Medicaid contracts in effect with HMO's. On February 1, 1993, there were 47 such contracts with an additional 48 contracts in development. The number of Medicaid recipients enrolled in HMO's increased 58.6% in the 10 month period subsequent to the effective date of subdivision 2-a.

6. To achieve the overall statutory goal of enrollment in Medicaid managed care programs of 50% of the non-exempt Medicaid population, approximately 1.1 million Medicaid recipients would have to be enrolled. To reach that goal by the year 2000, a net enrollment increase of approximately 10,000 Medicaid recipients per month would have to be attained, taking into consideration that some enrollees will become disenrolled for various reasons. While not all managed care enrollees will be enrolled in HMO's, HMO's continue to be, as pointed out in my previous affidavit, the primary source of case managed care in the Medicaid program. On April 1, 1992, Medicaid recipients were being enrolled

in managed care at a net increase of 3,000 persons per month. On February 1, 1993, the rate was 6,000 persons per month.

7. It is apparent from these enrollment statistics that the statutory enrollment goal cannot be achieved in a timely manner unless HMO participation in Medicaid continues to increase from the levels attained in the 10 month period subsequent to the effective date of subdivision 2-a.

8. As demonstrated by these figures, the 9% factor established under subdivision 2-a is a significant influence in the increased participation by HMO's in Medicaid since April 1, 1992. Elimination of the 9% factor without an alternative incentive in place would cause some HMO's either to limit their Medicaid participation or not to participate at all.

9. Based upon my experience with managed care, I believe that the improved quality, continuity and comprehensiveness in Medicaid health services to be achieved through increased HMO Medicaid participation would not be attainable as prescribed in the statutory scheme if the 9% factor is eliminated or additional time is not made available to develop a substitute incentive for HMO's and a substantial number of HMO's limit their participation.

10. The harm described in Paragraph 9 herein, that would result to the extension of managed care to a highly vulnerable and medically underserved population if a stay is not granted, could not be remedied even if the Court of Appeals were to rule in Defendants' favor.

By reason of the foregoing, the Defendants' application for stay of the Court's order in this action should be granted.

STUART L. LEFKOWICH

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Miriam A. Boggio, filed February 19, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

Miriam A. Boggio, being duly sworn, deposes and says:

1. I am a Deputy Superintendent of Insurance and make this affidavit in support of the motion of defendants, Mario M. Cuomo, Governor of the State of New York, Mark Chassin, M.D., Commissioner of Health of the State of New York, Salvatore R. Curiale, Superintendent of Insurance of the State of New York, and Mary Jo Bane, Commissioner of Social Services of the State of New York ("State defendants") for a stay pending appeal.

2. By Opinion and Order ("Order") dated February 3, 1993, this Court enjoined the State defendants from enforcing the 13%, 11% and 9% surcharges in the N.Y. Public Health Law against any commercial insurers or health maintenance organizations ("HMOs") in connection with their coverage of Employee Retirement Income Security Act ("ERISA") plans (Order p. 34).

3. The Court's injunction against these surcharges should be stayed pending the State defendants' appeal to the Second Circuit Court of Appeals because the injunction may result in irreparable injury to the States' insurance and health care system. Addressing my comments particularly to the 11% surcharge, the Court's injunction, if not stayed, will frustrate the State's efforts to

moderate the premium rates charged by the Blue Cross plans to their individual and small-group subscribers which had been dependent on the differential applicable to commercial insurers. This will contribute to continued erosion of the plans' community-rated pools. Subscribers may be forced to either drop coverage or move to commercial insurers. Blue Cross plans will, as a result, continue to face underwriting losses. Blue Cross will not be able to be restored to the *status quo ante* if the State ultimately prevails because they will be deprived of good risks and have little or no likelihood of getting them back.

4. The Department exercises authority over health service corporations and insurers who sell health insurance. Non-profit health service corporations, such the Blue Cross plans, historically have provided open enrollment, meaning they accept all applicants regardless of health status, and other benefits to the public. They utilize community rating practices for individuals and small groups in which the same premium rate is set for all persons covered by a policy form based on the experience of the entire pool of risks covered by that policy, regardless of the age, sex, health status, or occupation of the individuals in the pool. In addition, Blue Cross also provides most of the Medicare supplemental coverage and makes advance payments to hospitals which give them financial stability. Commercial insurers, on the other hand, either do not provide insurance to individuals or small groups or require evidence of insurability, exclude certain conditions from coverage, or require additional premiums because of the higher risk involved. However, despite the availability of health insurance to individuals and small groups on a community-rated basis through open enrollment by the Blue Cross plans, the Blue Cross plans have experienced a reduction in the total number of individual and small group subscribers which results in ever upward pressure on rates.

5. The community-rated pools of the Blue Cross plans have eroded because commercial insurers who experience-rate and

exclude individuals because of health status and occupation are able to maintain lower premium rates and siphon off the best risks. Between 1987 and 1989, for example, Empire Blue Cross, the largest New York health services corporation, lost 110,000 direct pay subscribers and 440,000 group subscribers. Thus, the utility of the 13 percent differential in providing a "level playing field" to these corporations in their competition with commercial insurers which can selectively underwrite their risks was diminished. This resulted in a competitive disadvantage to Blue Cross and an inability to maintain a mix of high, low and average risks. In response, the Legislature enacted the Governor's proposed legislation which required open enrollment and community rating by commercial insurers in the individual and small group marketplace. That proposal is effective April 1, 1993 (Laws 1992, ch. 501). In addition, the 11% surcharge to the commercial insurers' hospital reimbursement rate was enacted as part of the Omnibus Tax Revenue Act (Laws 1992, ch. 55, § 348).

6. The 11% surcharge was enacted in recognition of Blue Cross' special situation and problems described above and in more detail in the Clyne affidavit. If Blue Cross' community-rated pools continue to lose enrollment and their rates continue to increase, health insurance coverage will be unaffordable and inaccessible to even more New Yorkers. To the extent commercial insurers' rates reflect the additional differential, the rates charged by the Blue Cross plans will be more competitive, and good risks, both individuals and small groups, are more likely to enroll in Blue Cross. That would result in moderation of the Blue Cross rates, making health insurance more affordable to New Yorkers.

7. On the other hand, if the 11% differential is enjoined, the intended effect of a more competitive insurance marketplace will be blocked. Any salutary impact the 11% has on preventing the continued erosion of the Blue Cross community pools will not occur. Continued erosion of these pools will result in increased

underwriting loss, threatened insolvency of Blue Cross plans, and requests for additional rate increases which, if granted, will result in individuals and small groups dropping coverage.

8. This injury is irreparable because the Blue Cross plans cannot be restored to the *status quo ante* if defendants prevail. The plans have no way of reducing their rates to lure back the better risks who are being siphoned off by commercial insurers. The Blue Cross rates will continue to go up and the competitive disadvantage they face vis-a-vis commercial insurers will be exacerbated. The intent of the community rating/open enrollment bill, which is effective April 1, 1993, is to spread the risks by requiring that commercial insurers have the same underwriting practices as Blue Cross and eliminate selection of risks in individual and small group markets. The period prior to the effective date of that law provides an incentive for commercial insurers to intensify their efforts to obtain good risks from Blue Cross. To the extent they are able to do so, their community rates will be lower than the Blue Cross plans, and Blue Cross will remain at a competitive disadvantage even after that law takes effect.

WHEREFORE, I respectfully request that the Court grant the motion to stay the order pending appeal.

MIRIAM A. BOGGIO

[Jurat omitted in printing.]

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

Affidavit of Kathryn Allen, filed February 22, 1993

[Travelers Ins. Co. v. Cuomo and HIAA v. Chassin]

* * *

KATHRYN ALLEN, being duly sworn, deposes and says:

1. I am the Executive Director of the New York State Health Maintenance Organization Conference and make this affidavit in opposition to the motion of the defendants and the intervenors New York State Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield ("Blues") for a stay of this Court's Order and Opinion, dated February 3, 1993, insofar as the Order enjoins the enforcement of the 9% surcharge.

2. The New York State Health Maintenance Organization Conference is a not-for-profit corporation consisting of 27 health maintenance organizations ("HMOs") licensed to operate in and located throughout New York State. The HMOs in the Conference currently provide health care to more than 2.8 million people in New York. The twelve individual HMOs that also have intervened serve well over one million people in all parts of the State.

3. As Executive Director of the Conference, I am fully familiar with the operations of HMOs throughout the State. Prior to becoming Executive Director of the Conference, I was the Director of Marketing for Health Insurance Plan of Greater New York,

the largest HMO in the State and one of the oldest in the country. I also served as the Vice-President, Marketing, at Rutgers Community Health Plan in New Jersey.

4. Among my duties as Executive Director, I serve as the lead staff person for the Conference's Medicaid Subcommittee, comprised of representatives of all the HMOs in the Conference. The Medicaid Subcommittee meets six times per year to discuss methods for improving the ability of HMOs to serve the Medicaid population and to address special problems that arise with regard to such matters as contracting with counties, quality assurance standards, regulatory requirements and other issues unique to the delivery of health care through the Medicaid program. The Medicaid Subcommittee was formed more than three years ago.

5. I also have been designated by the Conference to serve on the Managed Care Policy Advisory Group. The Group was formed at the request of the Conference and is comprised of representatives of the State Department of Social Services, the State Department of Health, the State Department of Insurance, the Counties of New York State, including New York City, the HMOs and other managed care providers. The purpose of the Group is to coordinate efforts among State and local officials and managed care providers to expand managed care to the Medicaid population. The Group currently is meeting the equivalent of two full days per month and expects to meet pursuant to that schedule throughout 1993.

HMOs AND MEDICAID MANAGED CARE

6. Unlike other insurers, HMOs serve Medicaid recipients. Under the State's Medicaid Managed Care Program, HMOs enroll Medicaid recipients into their managed care networks and receive a fixed monthly rate for each individual. Each HMO bears the full risk for the cost of providing care to the Medicaid member. This is in contrast to the usual Medicaid fee-for-service

arrangement in which the Medicaid provider receives a fee for each visit or service. HMOs also insure that Medicaid recipients and their families have a primary physician who monitors their care on a regular basis. This and the availability of a health care network helps reduce costly emergency room visits and unnecessary hospital stays. HMOs currently serve more than 109,000 Medicaid recipients.

7. In April, 1992 the State enacted the 9% surcharge on HMO inpatient care (Chapter 55 of the Laws of 1992). The 9% surcharge is not an increase in the rates that HMOs pay hospitals. Rather, it is a separate charge that is based on the aggregate montly cost of the inpatient hospitalization paid by an HMO. It is paid directly to a statewide pool and thereafter deposited into the State's General Fund. In the case of HMOs that have negotiated alternative hospital rates, the 9% is assessed over and above the negotiated rate.

8. Under the existing statute, an HMO can reduce or eliminate the 9% surcharge for a given year if it (1) has Medicaid contracts with every county in which it operates (subject to certain "good faith" waivers) and (2) enrolls a defined target number of Medicaid recipients. The enrollment target for 1993 and each year thereafter increases until it reaches the State goal of 50% of the non-exempt Medicaid population. According to the State Department of Social Services this is approximately 1.1 million Medicaid recipients.

9. The process for obtaining a county Medicaid contract is lenghtly (approximately nine months) and additional time is necessary thereafter to enroll Medicaid recipients.

10. If an HMO were to stop enrolling Medicaid recipients and the State did prevail on appeal, realistically it would be impossible for the HMO to reenter the marketplace and satisfy the

enhanced target enrollment necessary for exclusion from the 9% surcharge.

11. In 1991 the Legislature enacted the New York State Managed Care Plan (Chapter 165), §364-j of the Social Services Law. This law requires the State Department of Social Services to designate up to twenty local districts annually which will be required to develop and submit managed care plans for approval by the Department, until all non-exempt districts in the State have been designated. In addition, the law sets an enrollment goal of 50% of each district's Medicaid population who are not exempt from participating in the managed care program within five years of managed care plan approval. In effect, this legislation compels counties, for the first time, to develop a managed care strategy and to turn to HMOs and other managed care providers to implement that strategy. The legislation was welcomed by HMOs because it removed serious impediments for HMOs that wanted to enroll Medicaid recipients but encountered apathy or refusal to contract on the part of the counties.

12. In the year following the enactment of Section 364-j of the Social Services Law, Medicaid enrollment in HMOs increased by 52%. This is particularly noteworthy since not all counties were compelled to participate in the first year of the program.

13. The Conference has long recognized its obligation to extend the benefits of Manged Care to Medicaid recipients and is institutionally committed to helping the State achieve its Medicaid enrollment targets pursuant to the State Managed Care Plan.

14. Each member plan of the HMO Conference has established an administrative apparatus and marketing strategy for contracting with counties and enrolling Medicaid recipients. In most cases this has involved hiring new staff and in all cases has involved substantial investment of resources that plans will need to recoup through continued expansion of Medicaid enrollment.

15. Currently, 24 of the 27 plans enrolled in the Conference, including ten of the eleven individually named HMOs, have Medicaid contracts and are enrolling Medicaid recipients. The remainder are involved in negotiations with counties to establish contracts and are prepared to enroll Medicaid recipients as soon as the contracts are in place.

16. Because of the requirements of the New York State Managed Care Plan and the enhanced targets for 1993 and beyond, members of the Conference will continue to aggressively participate in the Medicaid program even if a stay is not granted.

17. The Conference remains committed to help the State achieve its target enrollment goals pursuant to the State Managed Care Plan.

18. Accordingly, the motion of the defendants and intervenor Blues for a stay of the injunction against enforcing the 9% surcharge should be denied.

KATHRYN ALLEN

[Jurat omitted in printing.]